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ABSTRACT

This booklet, third in a three-volume series, presents a description of community coordination for managing and preventing child abuse and neglect. Within the context of the "community-team approach," various resources for identification and diagnosis, treatment and education are discussed. Chapters cover: (1) the community-team approach; (2) central registers (case indices), including their present status and organizational and operational considerations; (3) treatment programs for both parents and children; (4) education of the public and professionals, and public relations campaigns; (5) coordinating the components that make up a program, and guidelines for people wishing to start a community-team program; and (6) primary prevention measures. An appendix contains examples of community programs. (SB)

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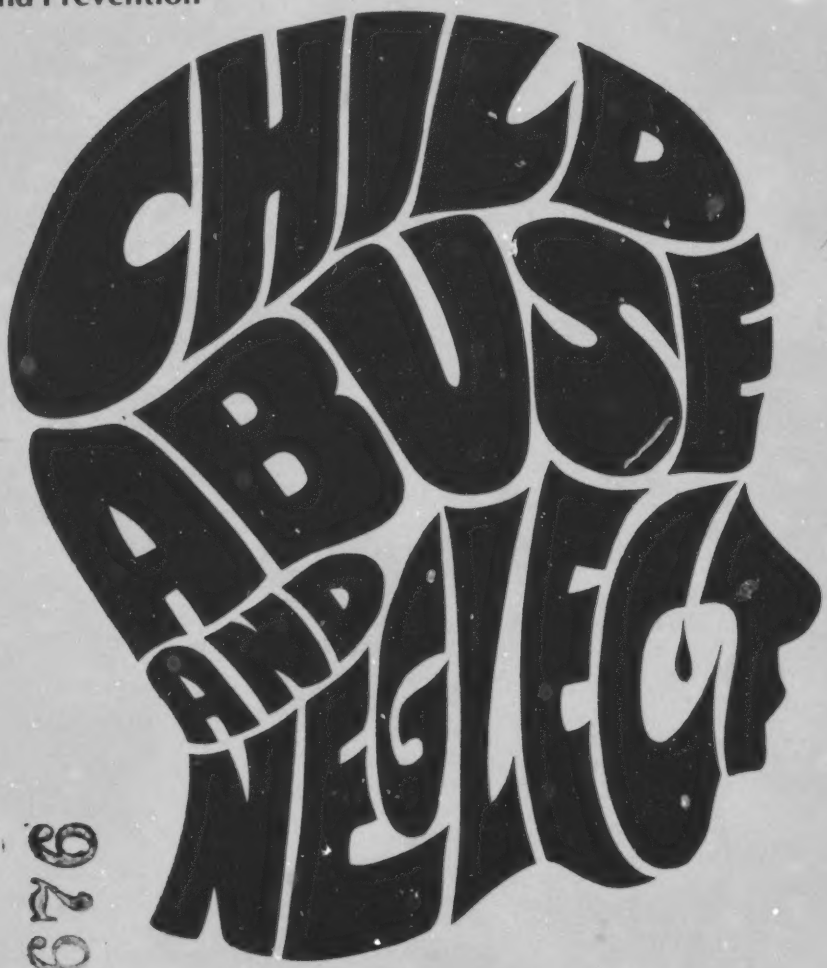
Volume 3
The Community Team
An Approach to Case Management
and Prevention

CHILD ABUSE AND NEGLECT

The Problem and Its Management

Volume 3

The Community Team
An Approach to Case Management
and Prevention



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The Problem and Its Management

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In preparing their materials for the series, many of the authors visited agencies throughout the country and interviewed various professionals in the field. Those whose ideas and opinions are expressed here are too numerous to list individually, although each deserves a personal thanks for the interest and information

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provided. (To simplify reading, information obtained via personal communication is not specifically referenced; all unreferenced quotes and paraphrased comments included in any of these volumes are the products of personal interviews, conducted in 1974.)

The original manuscripts on which the three volumes are based were reviewed by Mildred Arnold, Special Assistant to the Commissioner, Community Service Administration, Social and Rehabilitation Service, DHEW; Vincent De Francis, J.D., Director, Children's Division, The American Humane Association, Denver, Colorado; Phillip Dolinger, Program Supervisor, Child Protective Services, Minneapolis, Minnesota; Elizabeth Elmer, M.S.W., Director, Community Services, Consultation and Education, Pittsburgh Child Guidance Center; Frederick Green, M.D., Children's Hospital, Washington, D. C.; C. Henry Kempe, M.D., Director, National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado; and Eli Newberger, M.D., Director, Family Development Study, the Children's Hospital Medical Center, Boston, Massachusetts. While the views and opinions expressed in these volumes are not necessarily those of the reviewers, the National Center on Child Abuse and Neglect extends a special thanks to these and all the other individuals whose ideas and efforts are reflected in these pages.

Foreword

On January 31, 1974, the Child Abuse Prevention and Treatment Act (P.L. 93-247) was signed into law. The act established for the first time within the federal government a National Center on Child Abuse and Neglect. Responsibility for the activities of the Center was assigned to the U. S. Department of Health, Education, and Welfare, which, in turn, placed the Center within the Children's Bureau of the Office of Child Development.

The Center will provide national leadership by conducting studies on abuse and neglect, awarding demonstration and research grants to seek new ways of preventing, identifying, and treating this nationwide problem, and by giving grants to states to enable them to increase and improve their child protective services.

One of the key elements of any successful program is public awareness and understanding, as well as the provision of clear and practical guidance and counsel to those working in the field. It is for this reason that the National Center on Child Abuse and Neglect is publishing a series of booklets—three comprehensive and related volumes (of which this is one), and three shorter booklets dealing with the diagnosis of child abuse and neglect from a medical perspective, working with abusive parents from a psychiatric viewpoint, and setting up a central registry.

While some material in all these publications deals with studies of specific local programs as opposed to generalized approaches, they are not intended to represent categorical or *functional* models upon which other programs should be based in order to be effective. Rather, they are intended to provoke thinking and consideration, offer suggestions, and stimulate ideas. Similarly, the views of the authors do not necessarily reflect the views of HEW.

In the present series, *Child Abuse and Neglect: The Problem and Its Management,* Volume 1 presents an overview of the problem. It discusses child maltreatment from various perspectives, including characteristics of the parents and children, effects of abuse and neglect, a psychiatrist's view of the problem, and a discussion of state reporting laws. It also examines the many problems that make the abuse and neglect of children so difficult to comprehend and manage—from problems of definition and incidence to deficiencies within our system of child protection.

In Volume 2, the roles of some of the many professionals and agencies involved in case management are discussed: those working with abusive parents; child protective service agencies; physicians and hospitals; the police; and teachers and the schools.

Volume 3 presents a description of community coordination for managing and preventing child abuse and neglect. Within the context of the "community-team approach," various resources for identification and diagnosis, treatment, and education are discussed. The volume includes suggestions for developing a coordinated community program, examples of existing programs, and some current ideas on the prevention of child abuse and neglect.

This series of three volumes includes descriptions of many agencies and programs involved in managing the problem of child maltreatment. Again, each such description is intended as an example rather than as a model.

We hope that everyone concerned with detection, prevention, and treatment of child abuse and neglect will find some, if not all, of these publications of use in the vital work in which they are engaged. We hope, too, that these materials will be of use to those individuals and organizations wishing to become involved.

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Practical men, almost by definition, deal with the crisis of the moment, leaving the problems of tomorrow to take care of themselves. Scientists, by contrast, tend to be impatient of piecemeal solutions, and try to show us the larger picture into which the present crisis fits as only one piece of the jigsaw puzzle.

Scientists are likely to refer to practical men as "short-sighted." Practical men return the compliment by calling scientists "visionary." We can do without the pejoratives, for we need both sorts of vision and action. Present crises often demand immediate action, even though it be only palliative. A symptom may be more than a symptom: it may become a cause if it serves as the stimulus or excuse for other evils. Short-sighted action is often required; but let us expect no more than short-term benefits from it.

—Garrett Hardin
Population, Evolution, and Birth Control

Chapter 1
The Community-Team Approach

Child maltreatment, like other social problems, can be viewed from at least two perspectives. It is obviously the immediate and individual problem of any family in which it occurs—whether this "crisis of the movement" is the one-time abuse of a child by an adult under stress, periodic child torture or battering, or long-term physical or emotional neglect.

But from another perspective, the abuse and neglect of children is a reflection of more pervasive problems. According to Dr. Eli Newberger, the symptoms these children present can be seen "as an artifact of a system of child-rearing which encourages physical force and urges parents to coerce their children to conform to certain behavioral norms."[1] In still broader perspective, he adds that maltreatment can be viewed as "the final, tragic expression of a culture which deprives many young families of their needs for real services—such as health care, teaching about child development, day care, and adequate housing—and for the goods of society."

The goals of those concerned about the problem similarly span a continuum from the immediate to the visionary. At one extreme is the most basic goal: to save children's lives and to protect identified children from further injury. At the other end is a goal which may be stated in various ways. Some say it is to create a world free from all forms of violence. For others, it is to develop mechanisms to counteract the alienation, the destructive child-rearing patterns, the disintegration of family life, and the economic and social stresses from which we all suffer to some degree. However it is worded, the visionary's goal is to effect a radical change in the way we live as a society.

Between these two extremes lies a wide range of intermediate goals. While in many communities the most basic goals seem as unattainable as the most visionary, other communities are addressing themselves to tasks somewhere in between. Some are attempting to develop appropriate identification, intervention, and treatment programs for families in which children are maltreated. Some are trying to provide both crisis-oriented and ongoing social services for all families—the abusive and neglecting, as well as those in which children have not yet been hurt. Still others are working toward an increased awareness by professionals and public alike of the causes, nature, and outcome of child maltreatment.

The approach which a number of communities are taking to reach these goals is that of community-wide coordination and cooperation—the "community-team approach." This approach has been variously defined—from "people simply talking to each other," [2] to "a multidisciplinary diagnostic/treatment/and preventive program for families and children who have or are likely to have the problem of abuse and/or neglect." [3] For the purposes of this book, a community team is defined as a *body of professionals and the representatives of service agencies and groups who work together, using some form of coordination, to ensure more effective management of cases of abuse and neglect.*

However it is defined, the primary purpose of the community team is to upgrade the quality of protection for children and service to families. To quote Dr. Edmund Pellegrino of the National Academy of Sciences, Institute of Medicine: "The purpose of the group or team approach is to optimize the special contribution in skills and knowledge of the team members so that the needs of the persons served can be met more efficiently, effectively, competently, and more considerately than would be possible by independent and individual action." [4]

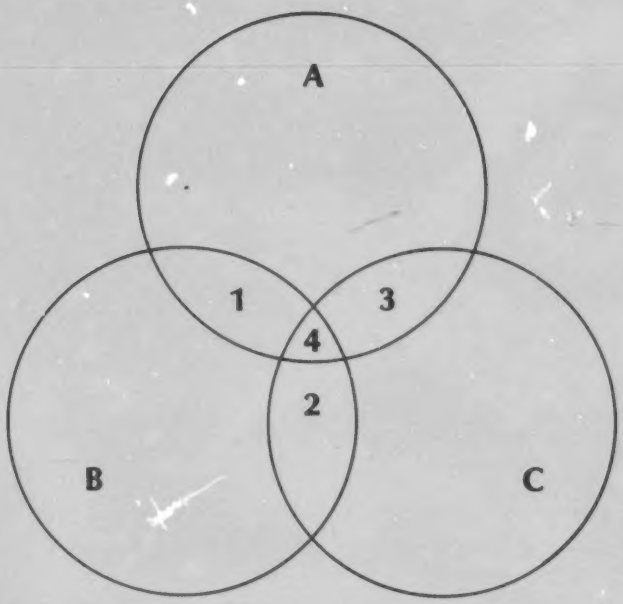
Community teams are fashioned by people within the community to meet particular local needs. Although the members vary with the community, teams generally include social workers, doctors, lawyers, juvenile or family court judges, psychologists, public health nurses, teachers, police officers, day care workers—in short, representatives of the agencies and groups that work with

children and families. Many community teams include private citizens as well.

Since group structure, tasks, and specific objectives will vary with the individual team, it is doubtful that any two community programs will be the same. Nevertheless, there are certain elements of service that each community *must* provide if children are to be protected, families are to be helped, and the abuse and neglect of children ultimately contained. These elements fall roughly into three groups, each of which is discussed in detail in Chapters 2, 3, and 4 respectively.

- The first has to do with *identification and diagnosis:* families having the problem of child abuse or neglect have to be identified—either through self-referral or by a third-person report—if they are to be helped; they must receive appropriate social, medical, and psychological assessment; and a treatment plan for each family must be developed.
- The second required group of services relates to *treatment:* identified children must be protected and given any necessary medical, psychological, and emotional care, and their parents must be provided with appropriate therapeutic and support services. The treatment plan for the family may include provisions for any number of services of any type —from long-term psychiatric services for the parents, an emergency loan, or visits by a parent aide, to temporary or permanent placement of the children, or their involvement in therapeutic day care.
- The third service element each community should provide is *education:* the community must be informed about child maltreatment both to broaden the base of potential reporters and to ensure public awareness of available help; professionals working with children must be taught to identify the signs and symptoms of abuse and neglect; and those directly involved in case management must receive additional specific training.

Identification and diagnosis, treatment, and education are components essential to a successful community program. Dr. Ray Helfer, in cooperation with both the Infant and Preschool Committee of the American Academy of Pediatrics and the National Center for the Prevention of Child Abuse and Neglect in Denver,



A—Identification and Diagnosis

B—Long-Term Treatment

C—Education, Training, Public Relations

1—Case Coordination

2—Professional Training and Recruitment

3—Public and Professional Education, Professional Training

4—Program Coordination

Figure 1. Helfer's Model of the Community-Team Program.

has developed a model of the community-team program* based on these three components.[5] As the diagram of this model in Figure 1 shows, coordination is the central interface of the program's component parts.

In common usage, community can refer to any area from perhaps a five-family village to the city of New York or Los Angeles. For the purposes of program coordination, however, Helfer feels that regionalization is necessary; and he defines as a "community" any geographic area with a population of 200,000 to 500,000. This number of people allows the necessary array of services to be developed while facilitating their optimum use. A program developed for a population smaller than this would lack either the variety of services individual families may require, or the clients needed to make the various services cost-effective. On the other hand, attempted coordination of a large metropolitan area such as Chicago, Los Angeles, or New York would lead to "undue frustrations and stumbling blocks."[6] By Helfer's definition, New York City would require some 20 community programs; while, in some states such as Wyoming, Alaska, or Vermont, there would be only one.

The discussions in this volume revolve around a central question: How can a community develop and coordinate its services in attempting to manage and prevent child abuse and neglect? While every community will, of course, have to answer this question for itself, this volume presents practical information about various aspects of the community-team approach. It includes discussions of alternative identification, treatment, and educational resources; a section of guidelines on community coordination; several examples of community teams functioning in different parts of the country; and some current ideas about primary prevention. The purpose is to offer information, alternatives, and encouragement to those working to help reintegrate families being shattered through inadequate parenting and to

*While the literature on child maltreatment is extensive, little has been written on the community-team approach. Models of hospital teams and discussions of the problems inhibiting community-wide coordination are abundant, but actual models of coordinated community programs are few. Helfer's model has been chosen because it is comprehensive, without being restrictive. In fact, as a general framework, it may be found to have value in the management of various social problems in addition to the maltreatment of children.

those working toward tomorrow's goal of preventing the abuse and neglect of children.

References*

1. Newberger, "Interdisciplinary Management of Child Abuse: Practical, Ethical, and Programmatic Issues," pp. 6–7.
2. Douglas J. Besharov, personal communication, 1974.
3. Helfer, *Self-Instructional Program on Child Abuse and Neglect*, Unit 5. Much of the discussion in this chapter is based on this unit.
4. Pellegrino, "Interdisciplinary Education in the Health Professions: Assumptions, Definitions, and Some Notes on Teams," p. 12.
5. Helfer, *Self-Instructional Program on Child Abuse and Neglect*, Unit 5.
6. Helfer and Kempe, "The Consortium: A Community-Hospital Treatment Plan," in *Helping the Battered Child and His Family*, ed. Kempe and Helfer, p. 178.

*Complete source information can be found in the bibliography.

Chapter 2
Identification and Diagnosis

The first component of the community-team program includes all the people, procedures, and resources involved in the initial phase of case management: the identification and diagnosis of families in need of protective intervention, and the development of a coordinated treatment plan for each.

Prime responsibility for case management in this initial phase lies with the child protective service (CPS) agency or, in some states, with other mandated agents such as the police. However, other persons are necessarily involved. Identification, for example, is the responsibility of all those mandated by law to report, generally professionals—physicians, nurses, teachers, social workers, and others—who have direct contact with children. In a broader sense, everyone in the community shares the responsibility for identification. Even those who are not legally required are often encouraged by their state's law to report.

Since some reported children require medical assessment and care, physicians and nurses are also directly involved in case management. The parents may require psychological evaluation by a psychiatrist, psychologist, or psychiatric social worker. The protective service caseworker, after evaluating the family, may need to consult an attorney on the handling of the case. In

some cases, the police will have to make an emergency removal of a child from the home. If temporary or permanent placement of the child is indicated, the case will usually have to be referred for adjudication and disposition to the juvenile or family court.

In the identification and diagnosis component, essentially five procedures are involved: reporting, investigation, intervention, assessment, and disposition. To be effective, these procedures must be viewed as an interrelated process.

Reporting. In most communities, the public child welfare agency is mandated to receive and investigate reports of suspected abuse and neglect. However, as noted in Volume 1, Chapter 3, many states divide this responsibility among two or more agencies.

When the responsibility for accepting and investigating reports is divided, the community is in danger of having "everybody's business become nobody's responsibility." Every community should designate one agency to receive, initially investigate, refer, and follow up all reports. The *Final Report* of the New York City Mayor's Task Force on Child Abuse and Neglect recommends this practice for two reasons: one central agency would have "prime responsibility for knowledge of a particular case"; and the centralization of this knowledge would facilitate "the most efficient flow of information."[1]

"Prime responsibility" would, in most cases, reside with the public child protective agency—the only public agency specifically addressed to the problem of child maltreatment. But there are communities where another of the legally mandated agencies fills this role. In Los Angeles, for instances, the police department's Abused and Battered Child Unit handles the receipt, investigation, and referral of all reports.

Regardless of which agency is designated as having prime responsibility, it should meet certain criteria: it should be able to accept reports 24 hours a day, seven days a week; ideally, it should be able to investigate emergency reports within an hour, and other reports within a day; it should maintain, at the local or state level, a central register of reports; and it should have

access to multidisciplinary consultation, as well as effective lines of communication with other agencies throughout the community.[2]

To facilitate reporting, the agency could provide a single telephone number as a 24-hour reporting line. Several states, including Florida and New York, have initiated statewide reporting systems which use one toll-free number for reports from anywhere in the state. Under such a system, reports are entered into the state's central register, correlated with any previous information about the family, and immediately transferred from the central intake office to the local CPS unit for investigation.

However, there are dangers inherent in efforts to facilitate reporting. One of the prime risks is the generation of an unexpected increase in reports before resources are developed to handle the increased caseload. Florida's experience with this situation is discussed in Chapter 4.

Investigation. As noted in Volume 1, Chapter 3, child protective agencies rely on fairly routine procedures in handling reports. Following an intake process in which the report is screened to determine whether CPS investigation is appropriate, the case is assigned to a field worker who must determine whether the report is valid and what if any action is necessary to protect the child and help the family. The investigation of reports requires both skill and experience. Discussion of investigative techniques and considerations is beyond the scope of this volume; detailed information is presented in *The Fundamentals of Child Protection** by Vincent De Francis, as well as various other sources.

One point that deserves mention here concerns the information generated through investigation. In addition to the investigating agency, other professionals involved in a family's assessment and treatment require information about the case. To avoid unnecessary duplication, information gathering should be standardized. The following is an example of what theoretically can happen to a case of abuse reported by a hospital in New York City.

*See bibliography for complete source information.

> An investigation is made by the Bureau of Child Welfare (under most circumstances disregarding the hospital report other than the medical findings) and more information is elicited from the parents. If the case is known to Public Assistance or to the SPCC, it is possible for them to involve themselves to protect the other children in the family, calling for one or two further intake investigations. Each new investigation may or may not start at the beginning—disregarding information obtained previously. The abused child may be placed away from his own family temporarily through remand, until a finding of abuse is made.
>
> Probation also has an intake procedure during which essentially the same information is obtained again. . . . It is also probable that with all the investigations made thus far, no *service* has been given the abusing parents—though they have now recounted their possible traumatic (to them as well) story five times.[3]

Ideally, all relevant basic information collected about a family should be available and acceptable to any other professional involved in the case. To approach this ideal, involved agencies should mutually determine the information generally needed, develop an intake form to include these data, take steps to ensure that information already collected is used by other agencies, and formulate procedures to ensure that the family's right to confidentiality is respected.[4]

Intervention. If initial investigation indicates a need for protecting the child, the investigating caseworker has three immediate alternatives, depending on the severity of the case: the child can be hospitalized; can remain at home under protective supervision and with support to the parents (homemakers, parent aides, or other such services); or can be removed to an emergency shelter or other temporary facility.

Kempe and Helfer stress that any child under the age of six, as well as most older children, should be hospitalized if there is a suspicion of abuse.[5] The American Academy of Pediatrics Committee on the Infant and Preschool Child advocates hospitalization as a means for providing the necessary time and resources for complete diagnostic evaluation.[6] In addition, until a more

thorough evaluation can be made, the hospitalized child is protected, while the parents are at least temporarily spared the shock of having their child removed "by the state."

Whatever form intervention takes, the professionals involved should be open and honest with the parents at all times. Sanders suggests that the initial contact between the parents and a professional can "affect the way the parents will later respond to suggestions for help." [7] The parents should be told that a report has been or will be made, and all decisions affecting the case should be explained and discussed with them. Through the expression of concern for the parents and the emphasis of their needs as well as those of the child, treatment begins the moment the diagnosis of abuse or neglect is considered.

Above all, the parents should never be accused of abusing or neglecting their child nor should they be cross-examined. As Kempe notes, the professional is not in a position to "play detective, looking for confession." [8] With patient and sensitive inquiry and respect for the family, the interviewer should eventually be able to determine the nature of the home situation.

Assessment. Probably the most critical step in case management, assessment includes the diagnosis of the child and the evaluation of the parents. If the family is found to be in need of child protective services, the caseworker must develop a coordinated family treatment plan on the basis of these evaluations.

In some cases, assessment requires medical diagnosis of the child and psychological or psychiatric evaluation of the parents in addition to the CPS worker's evaluation of the dynamics in the home. Particularly in severe or difficult-to-diagnose cases, assessment can be shared by members of a multidisciplinary diagnostic consultation team. Such teams often include the CPS caseworker, a pediatrician, a psychiatrist or psychologist, a nurse, and sometimes a hospital social worker and a lawyer. Each professional evaluates the child, or the parents, or the family as a whole; together they recommend to the caseworker the most feasible treatment plan.

Disposition. The help and advice of multidisciplinary consultants can be an invaluable asset to protective service decision

making; nevertheless, ultimate responsibility for developing and implementing a family treatment plan rests with the CPS caseworker or, in some cases, with the juvenile or family court judge.

Terr and Watson emphasize the importance of the "sequence of planning" treatment.[9] The first issue that must be settled is whether the child can safely remain in the home. If the child's safety is in question, even with careful protective supervision, and the parents refuse voluntary foster placement of the child, then the case should be referred to juvenile court. The next issue is the type or types of treatment best suited to the family. Whatever treatment plan is implemented, all rehabilitative and support services should be coordinated; treatment should be individualized to the needs of the child, the parents, and the family as a whole; and the case should be maintained as long as necessary.

In addition to the people and procedures involved in identification and diagnosis, there are various resources that can facilitate the initial phase of case management. Two of the most important, central registers and hotlines, are discussed in detail below.

Central Registers*

A central register is essentially an index of cases handled by an agency or a number of agencies. Registers of child abuse cases existed in Denver, Los Angeles, and New York City as early as 1964, and in Cincinnati and Milwaukee by 1965.[10] By 1966, California, Illinois, Virginia, and Maryland had statewide registers established by law;[11] and Colorado, Florida, North Dakota, and Utah maintained registers as a matter of administrative policy.[12] By early 1974, 46 states and the District of Columbia had central registers; of these, 33 were established by law, and 14 by administrative decision.[13] The number of statewide registers had increased almost 500 percent within a period of eight years.

The Present Status of Central Registers

To say that a state has a central register says little about the

*This section has been adapted from a booklet on Central Registers, written by Douglas J. Besharov for the Office of Child Development in 1975. Some of the material in this section was originally published in Mr. Besharov's *Juvenile Justice Advocacy* (New York City: Practicing Law Institute, 1974), and is used here with the permission of the publisher.

kind of facility it maintains. Registers vary in scope and purpose from those such as Indiana's, which merely collects statistical reports from county welfare departments each month, to those like New York's, which is set up for research and policy planning and for the diagnosis, evaluation, monitoring, and coordination of cases. In Georgia, the central register is a handful of 3 x 5 index cards in a shoebox-size file. In contrast, Tennessee's register will soon be expanded into a sophisticated, on-line, electronic data-processing system, with remote terminals for input and for access via catnode-ray tubes and computer printouts. In some states, such as California and Illinois, reports are made to local agencies which forward copies to the central register; in others, such as Florida and New York, reports are made directly to the register. Although most central registers are the responsibility of the state social service agency, California's register is maintained by the State Department of Justice, Bureau of Criminal Identification and Investigation; and the District of Columbia's by the Youth Division of the Metropolitan Police Department. In South Carolina, each county's department of public welfare is mandated to have a central register of reports.

In light of the proliferation of central registers broad and the uses to which they are put, the origins of the concept of a register of child abuse reports are surprisingly unclear. There was no outstanding research finding, publication, or national group that introduced the concept. In fact, since 1963, only three articles have been published on the subject.[14] None of the early model child abuse reporting laws made reference to a central register, or even to a single repository for reports within a given jurisdiction. To date, the American Academy of Pediatrics Committee on the Infant and Preschool Child appears to be the only nationwide group that has specifically recommended the central register. In 1966, it proposed that the agency that receives legally mandated reports "should establish a central register of all such cases." [15]

Though its origins are not documented, the central register seems to have grown from two quite different conceptual and professional frameworks. One was the medical conception of a register to assist the diagnosis of suspicious injuries by providing a record of previous suspicious injuries. The other was the social

science conception of a register to assist in understanding the problem of child abuse by providing statistical data. As a diagnostic tool, the register would provide a means of locating prior reports on a particular child or family; as a research aid, it would provide data on the characteristics of reported cases.

Most existing central registers, particularly those established by law, are said to have either a diagnostic or a statistical purpose, or both. But in their present condition, most registers are unused and unusable. Because the data in most registers are incomplete, inaccurate, and out-of-date, the typical central register is a largely ignored appendage of the state's child protective system. As a special committee of the American Academy of Pediatrics commented, "In general, communities and states lacking registries would like to have them; but those that have them are dissatisfied." [16]

The Diagnostic Purpose. In 1974, 27 of the 33 state laws creating central registers made specific references to the register's diagnostic purpose; [17] and several other states had administrative provisions for using the register to assist in diagnosis. Nevertheless, no state can point to more than a handful of instances where a professional has requested the register's assistance to diagnose suspicious circumstances. In most states, the register has never been used as a diagnostic aid.

In fact, few states have registers which could quickly provide requested information. Typically, there is insufficient staff assigned to the register; locating specific information usually requires a manual search of files; and personnel are generally unqualified or too busy to provide diagnostic consultation. Because few registers include follow-up information on reported cases, the recorded data are usually incomplete, inaccurate, unverified, and outdated. (One state's computerized register was inadvertently programmed so that every report automatically erased any prior report on the same child.) In addition, most central registers operate only during regular business hours—9 a.m. to 5 p.m., weekdays.

Although several states provide for telephone access to the register, a greater number require that requests for information

be made by mail. If the register contains a prior report, some states will notify the inquirer by telephone, but others respond only by mail. The professional who must make an immediate decision about the safety and welfare of a child obviously cannot afford to wait the three days to three months needed for a response from the register. The following incident, which occurred before New York's Child Protective Services Act was passed in 1973, illustrates the potential dangers of the mail-notification system.

> *In Erie County, New York, a case brought before the family court as a result of a report to the county's department of social services was dismissed for lack of sufficient evidence. More than two months before, the department had requested information from the state's central register concerning prior reports on the child or the family. Three weeks after the case was dismissed, the department received the register's response: a report of abuse had been made about the child some 10 months earlier. Because the report had been made in Westchester County, because the register's operation was slow, and because mail-notification was used, the information took more than three months to reach Erie County. By that time, the department had had to close the case and was unable to locate the family again.*

The Statistical Purpose. At least 27 state laws specifically mention research or planning as a purpose of the register.[18] But as presently organized, most central registers cannot provide the kinds of comprehensive and sophisticated data which agency managers and planners need to develop and improve child protective and treatment services. Rather than being used as a means to learn more about the problem of child maltreatment and to gauge the impact of the reporting process, the typical central register is little more than a statistical index of past and current cases. The only real use of most registers is in the preparation of statistical reports addressed to the most rudimentary questions: How many reports? From whom? Reporting what type of abuse? Even the data portrayed in these simple reports are inadequate for statistical use.

Because of fragmented and complicated reporting procedures, many reports received by local agencies are never forwarded to

the central register. In some states, the data in the register are neither complete nor consistent because the state does not provide printed forms for reporting to the register. In California, for example, ordinary arrest reports or "injured child reports," which differ with the community, are sent to the central register.

The scope of most registers is further narrowed by the exclusion of nonmandated reports—reports made to an agency other than that specified in the state's reporting law, made by a person who is not designated by law to report, or made about a form of maltreatment not covered in the legal definition. In 12 states, reports of child neglect are not expressly mandated;[19] and in 30 states, private citizens are not subject to the mandatory reporting law. The exclusion of either of these categories of reports from a central register would clearly have a serious impact on the statistical picture of child maltreatment in a state.

Compounding the problems caused by haphazard and incomplete collection of reports is the paucity of information in the register's files. The forms used to send information to the register are quite brief, containing little more than the basic data required by the reporting law. Data are typically limited to the identification of the child (age, sex, and address); a description of the alleged maltreatment; and the name of the suspected perpetrator. (In at least one state, the latter is purposely not collected.) Figures are therefore available for the number of cases reported, the ages and sex of children involved, the incidence by geographic area, the types of maltreatment reported, and the relationship of suspected perpetrators to the children. Such limited information tells little about the children and families involved. Data that would explore and document the patterns of abuse and neglect and the variations in family status, treatment programs, and dispositional alternatives are lacking.

Most registers cannot even reveal elementary operational needs. The reports they generate present a narrow and distorted picture of the child protective system, and provide little guidance for service evaluation and planning. For example, central registers often do not reveal problems such as what one state calls the "bank" or what another calls the "pending caseload"—reported cases that have not yet been investigated.

Generally, even the limited data that the register contains are not readily accessible for use and evaluation. Electronic data processing and immediate retrieval capability are rare. When a state reports that its register is computerized, this usually means that data on manual records have been key-punched for simple, numerical tallying.

Rethinking the Central Register

Various developments since the early 1960s have served to downgrade the original diagnostic and statistical purpose of central registers. For example, because of broadly expanded child abuse reporting laws, the register's original diagnostic function—to "enable the doctor or hospital to record concern that the child may be in an unsafe environment before the evidence is sufficiently specific that it can be reported"[20]—is no longer necessary. Reporting is now required when maltreatment is suspected; the reporter does not need specific "evidence."

Similarly, improved child welfare and social service record-keeping has outshone the register's statistical function in many respects. Some states are rapidly moving toward comprehensive social service information systems which provide more statistical data on all aspects of social welfare, including child protective services, than any but the most ambitious central registers.

It appears that many of the functions that have been assigned to registers might be fulfilled equally well or better by other community resources. Diagnosis and case management, for example, may be assisted as well and with less duplication by such devices as the social service exchange, the state social services information systems, or the agency master index. The same devices and random sampling of cases would certainly be sufficient for almost all statistical purposes.

Existing register systems are in a state of flux. Every year, 10 to 15 states amend their child abuse laws, including the provisions for central registers. At least two states, Maine and Minnesota, are dismantling their registers, apparently because of cost, duplication, and fears about the misuse of data. Yet many more states —including Connecticut, Florida, Idaho, New Jersey, New York, Tennessee, and Texas—are rapidly upgrading their registers' scope

and capabilities. However, states that choose to upgrade the register generally do so without rethinking its role in light of recent developments. As a consequence, these registers are likely to be as irrelevant to improved child protective services as their smaller and less costly predecessors.

Further refinement of central registers can be expected in many states. One reason is that the 1974 federal Child Abuse Prevention and Treatment Act, Public Law 93-247, provides for "technical assistance (directly or through grant or contact) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect."

In addition, the activities of The American Humane Association in testing the feasibility of collecting official child abuse and neglect incidence data from all states is having a catalytic effect in moving states to vitalize their registers and record-keeping systems. The association, which is collecting information on the incidence and nature of child maltreatment nationwide, has created an obvious need for "accurate, complete, and uniform" data from the individual states.[21]

There is no "true" or "best" approach to the operation of a central register. Each state must rethink the concept of the register in light of its own needs and capabilities, and must tailor its register system to its particular situation. The following pages present alternatives and considerations in the use and organization of central registers.

Uses of the Register

Properly organized and used, the central register can serve as one means to begin upgrading child protective services. The register is a largely untapped resource which could be used to coordinate many aspects of a system of child protection. It can be a prime tool for both immediate and long-term planning. If it keeps track of prior reports and treatment efforts, the register can provide immediate, concrete decision-making assistance to child protective workers and other professionals directly involved in cases. If it stores data on how reports are handled, the register

can monitor and measure the system's overall performance, and can present at least an elementary picture of the problems in the system.

Specifically, the uses of a properly operated central register include:

- Assisting diagnosis and evaluation by providing or locating information on prior reports and prior treatment efforts
- Providing convenient consultation to child protective workers and potential reporters
- Providing feedback to reporters
- Measuring the performance of the child protective service by monitoring follow-up reports
- Coordinating community-wide treatment efforts
- Providing statistical data on the handling of reports to facilitate research, planning, and program development
- Providing a focus for public and professional education campaigns.

Diagnostic and Evaluative Assistance. By providing information on prior reports involving a child or his or her siblings, the central register could facilitate the identification of abuse or neglect, and could assist in the diagnosis of danger to the child.

It is often difficult and sometimes impossible to know for certain whether a child has been maltreated. In general, the diagnosis of child abuse or neglect means that, based on certain signs or indicators (obtained through evaluation of the child's condition, of other members of the family, of the home, and of the psycho-social forces operating within the family), a professional has formed an *opinion* that the child has been maltreated. This decision, if seen realistically, is tentative and at times uncertain. In one survey, over one-third of the protective workers interviewed admitted their difficulty in verifying reports of abuse and neglect.[22]

Since child abuse and neglect are usually part of a repetitive or continuing pattern, information on the existence of prior injuries or other manifestations of maltreatment could help pro-

fessionals differentiate between the isolated accident and a condition that is part of a series of injuries or reports suggesting abuse or neglect. Knowledge of a previous incident, similar in kind, could turn doubt into relative certainty.

Some abusive parents "hospital shop," taking the child to a different doctor or hospital each time there is a need for medical care. As a result, a physician or other professional who sees the child for the first time will probably be unaware of previous injuries or suspicious circumstances. By providing such information, the central register can facilitate diagnosis. As an example, two hospitals in Albany, New York maintain and share information from files on suspicious traumatic injuries in children seen in the emergency room. Although their files are of more limited geographic scope than most central registers, and although the records list cases about which there is too little suspicion to report, the hospitals have identified 75 cases by pattern rather than by specific incidents.[23]

In some cases, a protective worker, physician, or other professional recognizes that a child is abused or neglected, but cannot assess the degree of risk in the home or the family's treatment needs. Knowledge of prior reports and their outcome can help gauge the seriousness of the family's situation and can be an important factor in determining whether the child should be immediately removed and which services the family needs.

William Ireland describes how the register can aid in evaluating a report and determining a family's service needs.

> Since the Central Index on Child Welfare Services and the Central Registry on child abuse are closely correlated, the same inquiry may elicit information on whether or not the child or family is being or has ever been served by the department or any of the voluntary child welfare agencies licensed by and reporting to it. This optional procedure may be interpreted as a diagnostic aid or simply as a means of reducing duplicated efforts. It is diagnostic in the sense that a child or family that has been reported previously on suspicion of abuse can be identified and the worker directed to the source of more detailed information. Even if no previous

report of abuse has been made on the family, a cross check with the index on child welfare services will reveal whether the family has previously been served by a child welfare agency and so may make it possible to get further background information to assist in diagnosis or service.[24]

Statewide registers can fulfill an added function—locating families who have moved from one county to another. While school, welfare, employment, and driving records are often helpful in locating individuals or families, they are sometimes unavailable or incomplete. In some cases, a statewide index is the only resource a worker has to uncover prior data on a family.

Many people question the need for wisdom of using the central register as a diagnostic tool. Their rationale is that the presence or absence of prior reports is used as a crutch by those who do not take the time or trouble to evaluate the family carefully. They fear that many children who should be reported will not be, and others who should not be reported will be.

But as others point out, the existence of a previous report should be only one factor in such decision making, just as the absence of previous reports or the fact that a prior report was unfounded should amount to only one factor to be weighed. Though information from the register accounts for only a small part of the diagnostic decision, the availability of the information is important. The existence of prior reports can effect a decision to report or to remove a child by revealing a pattern of injuries or incidents suggestive of maltreatment—a pattern that might otherwise not be recognized.

If a register is to be used for diagnostic assistance, it must include information on the outcome or present status of previously made reports. Lacking such information, the decision maker is left in the tenuous position of knowing that a prior report was made, knowing that many reports are unfounded, but having no idea whether the report on the child in question was valid. The following example of the difficulties this situation can create occurred in the emergency child welfare service of a large city.

At nine p.m. on a Friday night, a case of suspected child maltreatment was reported. The caller identified herself as

the aunt of three children, aged 12 months to five years, who were home alone while their mother was out on the town. A check of previous reports showed that two weeks before, a similar report had been made by the same aunt. However, because the agency did not include information on the outcome of reports in its central information system, the worker would have had to wait until Monday morning to learn what had happened from the caseworker's file.

The worker had no choice but to request that the police investigate the report. The police went to the apartment, located in a rough neighborhood, and knocked. Hearing footsteps but receiving no response, they broke down the door. Cowering in the corner were the three children and their terribly frightened, 14-year-old babysitter. The following Monday, the vindictive nature of the original report was revealed.[25]

The diagnostic potential of the central register has never been adequately revealed. Due to administrative failure to organize registers properly, to widespread concern over personal data banks, and to ambivalence about the underlying premise of diagnostic need, central registers have not yet been used to assist diagnosis and evaluation.

Consultation. If the register's staff has training and, preferably field experience in protective services, the register can serve as a means for convenient consultation. Both professionals and private citizens can often benefit from advice on whether to report, how to handle a particular situation, or what their legal rights and responsibilties are. The advantages of such consultation can be almost immediate in terms of more accurate diagnosis and improved handling of cases.

Feedback to Reporters. A person who reports suspected abuse or neglect is rarely informed of the disposition of the report, or even whether it was verified upon investigation. Requests for such information are sometimes refused on grounds of confidentiality. As a result, the reporter may feel isolated from efforts to protect the child. Unsure of the validity of his or her suspicions and of the consequences of the report, the person may hesitate to report again in the future.

If the law permits sharing the results of investigation with the original reporter, the register can be the vehicle for such feedback. The amount of information provided would, of course, be limited by the family's right to privacy and the source of the report. Only minimal feedback would go to nonprofessional sources.

Feedback on the validity of the original report can refine the reporter's ability to use the register for diagnostic purposes, and can thus improve the quality and accuracy of any future reports the person might make. Similarly, the return of information can also increase the accuracy of the data in the register by providing a "double check" on the information supplied.

Measuring Child Protective Service Performance. The central register is more than a compilation of reports of suspected child abuse and neglect; it is also an index of past failures of the child protective system. Every subsequent report on a family, unless made for malicious reasons, reflects a prior failure of the system to treat or ameliorate the family's problems. In New York state, for example, 20 to 30 percent of all reports involve previously reported families.[26] In this light, the register is hard-and-fast proof that children and families are not being helped enough. But the register is not only a critical measure of agency performance; it can be a prime tool for improving child protective services.

Protective workers often have dfficulty making the decisions their role requires. Because, in most states, there is no review of worker's decisions, a worker will sometimes avoid making a difficult decision—by convincing the parents to "voluntarily" accept services, including foster care, without determining their need for the services; by referring the case to the juvenile court for disposition; or by keeping the case open indefinitely "for services" or "counseling," not because the family is being treated or helped, but because the worker cannot make an alternate decision. Such avoidance techniques not only violate families' rights; they also make program planning impossible, since agency managers cannot know the size of the actual caseload and cannot gauge actual service needs.

Recruitment of sufficiently qualified staff and improved worker training will be needed to raise the adequacy of child protective services. But, for the short term at least, the central register can

be used to help protective workers better understand and meet their responsibilities. For example, workers could be required to send to the register follow-up information on reports. This practice would not only help structure the workers' decision making, but if the register monitors these follow-up reports, it could ensure that reports are investigated, that children are protected, and families helped.

The Wisconsin register reviews follow-up forms in order to assure their completeness, to follow up on missing or unclear information, and to identify and notify appropriate regional agencies of incidences of unmet needs (such as inappropriate intervention). Similarly, Alabama's Department of Pensions and Securities maintains on each child abuse case a central file which includes the report of abuse as well as correspondence from the county department relating to the family situation and the protective service being offered. If the department feels that appropriate protective action has not been taken, it follows up by letter or telephone.

In New York, protective service workers are required to send to the register a preliminary report of the investigation within seven days, and follow-up reports at regular intervals. This requirement prevents workers from avoiding difficult decisions on how to manage individual cases. In addition, the inclusion of casework reports in the register allows statewide monitoring of cases, provides a centralized and constantly updated picture of the management of each case, and lessens the danger of lost referrals and lost information.

Of course, using the register to follow up on reports requires a sophisticated tabbing system. A register with follow-up capability is an unparalleled tool for managing and monitoring the handling of cases. With automatic review capability, the register can help establish agency and worker accountability. A system that requires progress reports from intake through disposition encourages workers to make early and precise decisions on the service needs of individual clients. It can also generate case-management data that can be used to measure such variables as the length of each stage of the protective decision-making process; services given as compared to services requested; and total case-

worker time spent with each case, classified by type of case and type of activity.

Coordination of Treatment Efforts. Therapeutic and rehabilitative services are delivered by a social service system that is fragmented and uncoordinated. Scarce resources are shared, divided, and duplicated among local child protective agencies, police, juvenile courts, hospitals, and various other public and private agencies. Referrals for treatment must be followed up if sufficient protective and rehabilitative services are to be assured.

Used as a case-management and case-monitoring device, the central register can lessen the barriers between agencies by providing a constantly updated picture of the present handling of individual cases. Protective workers making referrals to community-based treatment programs could feel secure in knowing that the register will follow up on the family's progress in treatment. Because it will have an up-to-date picture of primary case responsibility, the register will further lessen the danger of lost referrals and information.

Research, Planning, and Program Development. After one hundred years of organized child protective efforts, many of the fundamental questions about child maltreatment remain unanswered. No one knows why some parents maltreat their children while other parents, in the same situation, do not. We are not even sure how best to structure crisis intervention.

The child protective system lacks meaningful data on the characteristics of its clients and how they are served. Agency planners lack a sufficient information base for intelligent planning and program development. They need statistical data to gauge the effects of different services and treatment approaches. Virtually all efforts to plan and develop services are hampered by a pervasive lack of adequate, objective, and quantifiable information about the incidence of child maltreatment, its effects on the various individuals involved, and how agencies handle these cases. Without objective evaluation of the methods of treatment, it is difficult, if not impossible, to make rational choices about what kinds of treatment programs should be developed and to whom they should be directed.

No activity, process, program, or administrative procedure in the child protective system operates so smoothly that it could not benefit from systematic scrutiny, evaluation, and improvement. The impact and effectiveness of reporting laws, the deployment of emergency services, the operation of central registers, and the impact of different intervention and treatment techniques are part of a broad range of procedural and treatment issues needing to be further studied and understood.

Central registers, created in part for this purpose, have so far failed to provide the necessary data. As a result, planning for children and families cannot be conducted in a predictable or reasoned pattern. In general, agency planners cannot give the comprehensive direction that child protective services need. They cannot maximize the effectiveness of existing resources; cannot assign priorities in the development of additional resources; and cannot point to a concrete record of accomplishment or need.

Organized and operated properly, a central register could analyze the extent, nature, and demography of reported child abuse and neglect; reporting patterns and compliance with the reporting law and administrative procedures; the use of the register for diagnosis and evaluation; the deployment and effectiveness of child protective personnel; and the impact of treatment programs.

But a central register is no better than the quality of its data and their potential for useful application. In the past, too little attention has been paid to what should go into the register, and how it should be collected and entered. If the register is to be used only for research or planning purposes, there is no need to accumulate data on every case. All reported cases do not have to be examined in order to determine, in a statistically valid manner, the age distribution of the children reported, the distribution of the nature of abuse reported, and so forth. Random sampling of the caseload will suffice. If a sampling of 1400 households can lead to a prediction of the outcome of a presidential campaign within one or two percentage points of accuracy, it is not necessary to read every file or to have a printout on every case reported to the register.

Modern information systems can generate great quantities of data without providing the information needed by management

in a usable form. The statistics, charts, and reports a central register can generate have the potential to overwhelm managers with enormous quantities of data, much more than they can possibly ever read, let alone use. If unchecked, the mania for collecting statistics can be the undoing of central registers.

Finally, statistical information must be pursued and used with caution. Conclusions about cause-and-effect relationships in the real world of child maltreatment can be superficial. True relationships are complex and inextricably interwoven with many different, and sometimes hidden, factors. Even now, the most basic relationships are poorly understood. For example, it is often misleading to attempt to apply scientific measures of cost effectiveness to child protective procedures. Even numerical costs include both direct and indirect burdens that cannot always be discovered. Furthermore, numerical measures tend to oversimplify and distort issues, since considerations such as justice, individual liberty, rights of privacy, and humaneness are beyond the realm of quantification. The cost-effectiveness approach should not be used to decide questions involving unmeasureable human values.

Public and Professional Education. By collecting, analyzing, and disseminating statistics and other information on the incidence and severity of child maltreatment, the central register can help alert people to the nature and extent of the problem locally. In addition, if the register serves as the 24-hour recipient of all reports, it can become a convenient and dramatic focus for public and professional education. Instead of presenting a complicated discussion of where and when to report a particular type of maltreatment in a particular community, the campaign's message could be: "If you suspect that a child is abused or neglected, call the central register."

Organizational and Operational Considerations

Most state laws, with a few exceptions, do not specify the operations of the register. In general, they provide only that a specific state agency "maintain a central register of reports," note its diagnostic or statistical purpose, and in some states describe the data that are to be contained. The register's organization and its mode of operation are left to administrative decision.[27]

Before a central register is established, concrete and broadly accepted decisions about its functions and operations should be made. On the following pages, some of the issues that warrant careful consideration are discussed.

The Agency Responsible for the Register. All but a few existing central registers are maintained by the social service agency having prime child protective responsibility in the state. It would be advisable for all states (and communities operating registers) to adopt this practice. If one agency receives, investigates, and follows up on reports but does not maintain the register that stores them, there is a greater risk of misuse of the register and greater likelihood that the register will not be used at all. For example, it would be impractical, if not impossible, to use such a register for casework monitoring. In effect, protective workers would have to make follow-up reports to another agency which would, in turn, have to supervise their day-to-day activities.

Geographic Scope. Central registers now operate at the city, county, or state level. There are currently 46 statewide registers. In South Carolina, registers are countywide in scope. Some states have a two-tier system, with registers at the city or county level in addition to one for the entire state.

In deciding geographical coverage, at least three considerations must be balanced: the transience of the population; the cost of maintaining the register; and the confidentiality of the names and histories recorded.

Like U.S. families in general, families in which children are abused and neglected are geographically mobile. Although their movement sometimes results from the desire to escape detection, their transience for the most part appears to stem from the same social and economic forces that cause Americans in general to move. Since abusive and neglecting families move not only within cities, counties, and states, but throughout the country as a whole, local and even statewide registers seem to have limited value for diagnostic purposes. To maximize the diagnostic function of registers, it would seem most appropriate to have a system of data exchange between the registers of individual states. Some states are already encouraging such cooperation. Texas law, for example, states: "The department may adopt rules and regulations as are

necessary in carrying out the provisions of this section. The rules shall provide for . . . cooperation with other states in exchanging reports." [28]

The strongest argument in favor of broad geographic coverage concerns cost. Economically, it is unrealistic to establish a 24-hour, seven-day-a-week service that may be needed after hours only once a week, as probably would be the case in any small-population area. New York's statewide operation serves a population exceeding 18 million, handles more than 70,000 cases annually, and costs over $400,000 a year. To reproduce the statewide system in Erie County, New York, which has a population of 1,200,000, the cost would be almost $200,000 a year. While New York law permits any county to set up its own register system, only one county outside of New York City has done so to date.

The broader the geographic coverage of the register, the greater the potential to match previous reports for diagnostic and evaluative purposes, to ensure unbiased monitoring of the protective process, and to achieve economies of scale. But there are disadvantages to increased coverage. As the register's geographic scope expands, the bond of local cooperation and trust can deteriorate. In addition, because the larger quantity of data attracts more attention, and because broader coverage requires the register's staff to respond to inquiries from distant and unknown callers, there is greater danger of unauthorized access to confidential information. Limited geographic coverage makes it easier to secure the confidentiality of records and facilitates cooperative, trusting relationships between the register's staff and local child protective professionals. (Measures to protect the rights of reported families are discussed later in this chapter.)

Contents. If the central register is to fulfill its prescribed functions, its contents must be complete and accurate. Because of the often hazy distinctions between abuse and neglect, the register should include data on all cases of child maltreatment, even those not specifically covered in the state's reporting law. In some communities, as much as 90 percent of the total CPS caseload involves cases of maltreatment other than physical abuse. To limit the register's contents to particular cases of maltreatment would produce a highly inaccurate picture of the local incidence of abuse and neglect. Hundreds or perhaps thousands of endangered children would be excluded from the register's

records. In turn, the diagnostic, statistical, and monitoring functions of the register would suffer.

Similarly, the contents of the register should not exclude reports on the basis of the reporting source or the agency to which they are made. Unless the register receives all reports of suspected child maltreatment made to any local or state agency, protective workers and other professionals cannot rely on the register for diagnostic assistance, agency administrators cannot rely on it to measure agency performance, and planners cannot rely on its data to assess programmatic needs.

Each record in the central register should contain at a minimum the following information:

- Identification and demographic data, including the name, address, age, sex, and race of the child and of his or her parents or guardians; the name of the person or persons responsible for the suspected maltreatment; and family composition and economic status
- Information about the initial report, including the nature and extent of the child's injury or condition, as well as any evidence of prior injuries, abuse, or maltreatment to the child or his or her siblings; identification of the reporter, his or her occupation or relation to the family (friend, relative), and where the reporter can be contacted; a summary of the actions taken by the reporting source, such as taking photographs and X-rays, placing the child in protective custody, or notifying the medical examiner or coroner; and the date and time the report was received
- Information on the handling of the report, including an initial evaluation by the child protective agency of the family situation and the risk to the child and his or her siblings; the actions taken or contemplated; whether the report was unfounded or indicated; the plan for family treatment; services offered and services accepted; and an evaluation of the child protective and treatment process including, when indicated, an evaluation of the family's needs that have not been met, needed services that are not available, existing services that are unsuitable, and the family's need for additional services.

Mode of Operation. As noted earlier, registers can be operated in various ways. They range from index-card files to sophisticated computerized systems. They may be open a few days a week during regular office hours or may operate on a 'round-the-clock basis. Their design and operation are, of course, determined by their functions.

Although most child protective decision making is safely made between 9 a.m. and 5 p.m. weekdays, situations requiring access to the register do arise after regular office hours and on weekends. To provide diagnostic and evaluative assistance, the register must be conveniently available at any hour, any day. To facilitate both reporting and access to the register, many states use a statewide, toll-free telephone number for the register that is open 24 hours a day.

A computerized central register combined with a statewide system of remote access terminals, much like Tennessee's developing system, would be an optimum system for many states with large child protective caseloads. But it is not a necessity. An upgraded central register can be operated satisfactorily with electronic data-processing assistance. For example, during the first year of operation of New York state's new register, some 60,000 initial reports and over 75,000 progress reports were processed manually. The register's staff was never more than one or two days behind in its workload—which is generally equal to or perhaps less than the lag in a computerized system of the same size.

All the operations of a central register depend on the skill of and the resources available to its staff. If there are too few workers to receive and enter reports and to respond to personal inquiries, if staff members are not adequately qualified or trained, or if there are not enough incoming and outgoing telephone lines, the effectiveness of the register will be compromised, and its work may grind to a halt.

Access. Information in the central register should be confidential; it should be made available only to certain specified persons under specified conditions. Limiting access to the register clearly limits its use; yet broadening access increases the possibility of its misuse.

Although several states allow all mandated reporters direct access to the register, most states severely limit access. Direct access to the register's information is often restricted to child protective workers. Of 27 state laws that assert a diagnostic purpose for the register, only 12 allow access by physicians.[29]

The reason for limiting access involves a twofold concern over the misuse of the register's information. First, large-scale access to the personal and family data in the register unreasonably compromises the right to privacy of those whose names and histories are recorded. If all mandated reporters are allowed access, there would be immense practical problems in guarding against unauthorized disclosure of information. One alternative would be to give an identifying code number, much like a credit card number, to each person mandated to report. To obtain information from the register, an individual would first have to recite his or her code number together with a password. (Tennessee will require this procedure for access to its computerized central register; but in Tennessee, only protective workers are granted access.) Fraser suggests a simpler but less secure system.[30] The person requesting data would have to give his or her name and address. Once the requested information is obtained, the operator can check the given identification with the listing in the city's telephone directory. If the name and address can be cross-referenced and if the person is mandated by law to have access to the information, the operator will telephone the inquirer and give the requested data.

The second concern over misuse of the register is that many individuals may not know how to use the data intelligently. As discussed earlier, a potential reporter could use the presence or absence of a prior report as the sole determinant for reporting or not reporting a child. Many states therefore withhold from potential reporters information about previous reports, particularly since the law requires the reporting of reasonable suspicions only.

Both these arguments lead to the conclusion that direct access should be limited to protective workers. But the issue of access to the register cannot be settled so easily, since other professionals must often exercise child protective responsibility. For instance, in all states, the police have the legal authority to place

children in protective custody; and, in many states, physicians also have this authority. A doctor seeing a bruised or emaciated child in a hospital emergency room must determine not only whether the case should be reported, but also whether the child should be allowed to return home. One part of the physician's decision relates to the possible risk to the child between the time the family leaves the hospital and the protective worker's visit to the home; an equally serious risk, particularly in urban areas, is that the family will disappear into the anonymous city.

Professionals having decision-making responsibility similar to that of CPS workers should be allowed access to the same information that protective workers can use. Although the sharing of information between professionals is often a suitable alternative to direct access to the central register, it is not a practical solution for the police officer or physician who needs particular information quickly or at times other than during regular working hours. To minimize potential misuse of information, those authorized to have access, including protective workers, should be trained in the register's use; records should be updated with follow-up reports; and unfounded reports should be removed. Any other professional having contact with an abused or neglected child should be able to obtain needed information through consultation with local protective workers.

If the register is to be used for monitoring and research, its data should be available to such individuals as academic researchers, policy planners, and legislators. Child protective services need the advice and assistance of universities, corporations, and various other institutions and groups. There is no sharp line dividing the research that agencies can do internally from that which is more appropriately performed by independent researchers. But those outside the child protective system are generally better able to question its long-accepted assumptions, to explore new modes of action, and to conduct long-range research which could lead to basic alterations in the system's structure and functioning.

In an effort to protect the rights of families about whom data are recorded in the register, agency managers should not lose sight of the legitimate informational needs of outside researchers and investigators. An agency's mistakes and weaknesses can easily remain hidden behind the cloak of confidentiality.

The subjects of a report in a central register—that is, any reported child and his or her parents or guardians—should also be granted access to the register. They not only have a right to know the recorded allegations concerning their family situation, but only with knowledge of the contents of the record can they pursue their legal rights to have the record amended or removed.

Protecting Civil Liberties

Although some people are unduly concerned about the existence of data banks, there is no question that they pose a potential threat to families' individual liberty and ability to reform. Central registers often contain the unverified suspicious of thousands of individual reporters. Many reports received, stored, and made easily accessible by central registers prove to be unfounded —depending on the community, between 10 and 60 percent. Sometimes, neighbors or relatives report for malicious reasons; more often, well-intentioned reporters are simply mistaken in their suspicions. But whether the reports in the register are confirmed or unfounded, it is essential to protect the rights of those reported. The register contains information on the most private aspects of personal and family life. There is a definite risk that improper disclosure or misuse of these personal data could stigmatize reported children and families.

As an example of the potential danger, a worker from Massachusetts noted that some automobile companies are identifying high-risk groups as a means of determining potentially poor insurance risks, and that one of the factors being examined is family stress.[31] Without appropriate provisions regarding disclosure, it is impossible to be sure how information released from the register may be used.

The coming computerization of registers, with easy electronic retrieval of information magnifies the potential dangers as well as the potential benefit of registers. As more states seek to improve the accessibility and usefulness of the information in their registers, greater consideration must be given to the uses to which the material is put and the conditions under which it is used.

In most states, at present, those reported are not informed that their names have been entered into the central register;

they are not permitted to see their files; they cannot have unfounded information removed; and they have no right to appeal. Often, there is no provision to ensure the security or confidentiality of the register's data.

A typical response to these facts is that the protection of children inevitably results in the compromise of parents' rights. However, both the law and the central register, while designed to protect endangered children, can also protect the legitimate rights to privacy of reported children and families. There are legitimate needs to maintain central registers, but the need to store and use personal information about individuals and families should not forestall efforts to prevent the register's misuse. All the civil libertarian criticisms of central registers (with the exception of the generalized fear of personal data banks) can be avoided through intelligent planning.

After studying the competing needs of administrative efficiency and citizen's rights, the U.S. Department of Health, Education, and Welfare's Secretary's Advisory Committee on Automated Personal Data Systems made a series of recommendations concerning the maintenance of social data records. The following recommendations of the committee are directly applicable to central registers.

- There must be no personal data record-keeping systems whose very existence is secret.
- There must be a way for an individual to find out what information about him is in a record and how it is used.
- There must be a way for an individual to prevent information about him that was obtained for one purpose from being used or made available for other purposes without his consent.
- There must be a way for an individual to correct or amend a record of identifiable information about him.
- Any organization creating, maintaining, using, or disseminating records of identifiable personal data must assure the reliability of the data for their intended use and must take precautions to prevent misuse of the data.

- There should be civil and criminal penalties for unauthorized use of information.[32]

It should be noted that such protections are parallel to those being established for credit and financial records.

In order to protect the subjects of a report in a central register, there is a need to ensure the accuracy and integrity of the information recorded, and a need to limit the use of recorded data to the register's relatively narrow functions.

To ensure accurate information, the subjects of a report should have the right to review the contents of their file and to make appropriate application to amend or remove the material. In Connecticut, welfare department regulations provide that the parents of a reported child may request that the welfare commissioner remove the child's name from the register; if the request is refused, the parents will be notified in writing of the reasons for the refusal. New York's 1973 Child Protective Services Act guarantees children, parents, and other subjects of a report the right to receive a copy of all information contained in the central register. However, the state commissioner is authorized to prohibit the release of data that would identify reporters or anyone who cooperated in a subsequent investigation, if the commissioner reasonably finds that such disclosure will jeopardize their safety or interests. In addition, the subject of a report may request that the commissioner amend, seal, or expunge the record of the report. If the commissioner refuses to comply within 30 days, the subject has a right to a fair hearing to determine whether the record should be amended or expunged on the grounds that it is inaccurate or being maintained in a manner inconsistent with the law.

Statutory provisions in at least four states and administrative provisions in others require that records be automatically sealed or removed if they are unfounded or otherwise inappropriately made or kept. In addition, some states have provisions to seal or remove a record once the child reaches a particular age, usually 18 years.

In order to restrict the use of data in the register to a narrowly defined group of persons having a legitimate need for the infor-

mation, 13 states have legislation limiting access to the central register. As noted earlier, these laws generally grant access to child protective workers and sometimes to physicians, police, and the courts as well. In eight other states, the register's records are confidential, and the agency that maintains the register is authorized to allow access to certain persons. Some states have no specific statutory provision regarding the confidentiality of the register, but rely on the general confidentiality of social service records to limit access to records in the register. In addition to limiting access to specific persons, some states prohibit telephone access to the register. Finally, an increasing number of states are enacting provisions for criminal and civil liability for the unauthorized disclosure of information from the register.

Legal restrictions on the use of the register are essential. The central register can prove to be an invaluable asset to a community's efforts to manage child abuse and neglect. But unless its function is explicitly defined, its design and operation carefully planned, and its information closely guarded, the register can prove to be a device that not only wastes money and stores useless data, but compromises the rights of children and families.

The central register is an attractive technological solution to a complex social problem. But its potential is easily exaggerated and its utility easily compromised. The mere establishment of a central register, even if it is the most elaborate and promising of systems, is not the end of the process of improving child protective services. But it is a good beginning.

Hotlines*

Several weeks before the Child Abuse Listening Mediation (CALM) hotline started up in 1970, Enid Pike visited a number of Santa Barbara agencies to explain the new service that she helped create and to solicit their cooperation. She was surprised to discover a good deal of skepticism. The purpose of the hotline was to receive reports of suspected child abuse and to offer direct assistance to callers who feared harming their own chil-

*Much of this section has been adapted from material written by William E. Howard for the Office of Child Development in 1974.

dren. It was the self-referral part of the service that professionals questioned: "What parents would pick up the phone and admit to a stranger that they had hurt or even contemplated clobbering their children?" Yet in CALM's first year, 30 percent of the hotline's calls were self-referrals from parents. The proportion of self-referrals has since risen to 72 percent of the total number of calls CALM receives.

The CALM hotline incorporates the functions of the two basic types of telephone hotlines: the reporting line, set up to facilitate reporting of suspected child maltreatment; and the crisis-intervention line, aimed at helping parents who call out of fear of hurting their children.

This section deals primarily with the crisis-intervention hotline, but this focus should not imply that the reporting line is without value. Florida, New York, and Illinois are among the states having public-supported reporting hotlines; and many metropolitan welfare departments operate similar 'round-the-clock services. These telephone-reporting systems tend to be well publicized and focused on immediate investigation and intervention. But while reporting lines have produced an often-dramatic increase in reports, most receive relatively few self-referral calls from parents. As Jeanette Dille, the executive director of Connecticut's Child Care-Line, a citizen-run hotline, has observed: "Few people are going to call an official hotline and say they need help to prevent them from hurting their children. They are too afraid that there'll be a policeman or a social worker at their door and that they'll find themselves in a worse mess."

The crisis-intervention line, on the other hand, is specifically designed to reach these parents. It is similar in many respects to other special-purpose hotlines, such as those providing crisis intervention for suicide prevention, drug abuse, teenage problems, and venereal disease. The crisis-intervention line provides an instant outlet for the distressed parent through the listener or answerer on the other end of the line. The caller can maintain his or her anonymity, knowing that there is no obligation to accept the assistance offered.

The crisis-intervention line has a decidedly more complex function than the reporting line. The ultimate purpose of both

is to provide help for parents and protection for children. Yet the reporting line functions specifically as a resource for identification of abusive and neglecting families, while the crisis-intervention line can serve as a therapeutic and preventive resource as well as an identification device. The hotline functions therapeutically when the listener can provide immediate understanding and support for parents in a time of crisis. It functions as a preventive mechanism when parents can release their frustrations through talking with the listener rather than through venting their feelings on their children. And it serves as a resource for identification by allowing parents in need of help to identify themselves.

Individual hotlines vary in the services they provide. Some function mainly as a referral service—they refer callers to appropriate community services and check back to confirm that the referral contact was made and whether alternate or additional referrals are needed. Others with professional listeners supplement referrals with crisis counseling over the phone. Still other hotlines provide volunteers who visit the parents in their homes.

The following discussion makes no attempt to present a model of the ideal service. Rather, it focuses on the problems one can expect and the issues one should consider in planning and operating a hotline.

How to Set Up a Hotline

There are no hard-and-fast rules for setting up a hotline, but there are a number of organizational and operational issues that have to be considered. As a first step, several basic questions should be answered:

- Is the service really needed? Will it duplicate an existing service?
- What area will the hotline serve? What is the potential number of callers?
- Is the service prepared to deal with every type of call relating to child maltreatment—from parents in need of help and from others reporting incidents of abuse or neglect?

- Can the hotline be integrated with other community services to provide meaningful assistance to families?

As a means of answering such questions, the founders of several present hotlines began by conducting careful surveys of hotlines operating locally. Surveys can be invaluable for determining potential duplication of service. In addition, experienced hotline administrators, even those functioning in a different area of crisis intervention, can provide practical suggestions and guidelines on defining the area and population to be served, handling calls, setting up the phone service, obtaining funds, and other operational concerns.

Another helpful preliminary step is to review the literature on hotlines. While little has been written on hotlines for abusive and potentially abusive parents, there are numerous articles on the development, operation, and impact of other types of crisis-intervention lines.[33]

Having some understanding of the problems inherent in operating a hotline, one should answer the following question honestly: How well equipped am I to sustain such a service professionally, emotionally, and physically? It is easy to be misled by the "glamour" of starting a hotline. However, establishing and operating a hotline has to be seen realistically—it is a commitment to an endless amount of difficult work. The experience can be rewarding, but only if the service is truly responsive to the needs of callers.

Authorities at the National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver feel formation of hotlines by well-meaning but inexperienced groups should be discouraged. As one Center official explains: "We hear too often about some housewives raising money through a bake sale, setting up a telephone, and advertising the number between the T.V. soap operas. When they start to get calls from parents in trouble, they become frantic—they don't know what to do with them. As far as I'm concerned, private-group hotlines are almost worthless unless they have professional backup or the ability to coordinate resources and make referrals in the community."

Officials at the Center suggest that hotline listeners should ideally be professional social workers. They also emphasize the

need for structured handling and follow-up on calls: there should be a standard procedure for a social worker or a trained volunteer to make the initial contact with the parent, for review of the case (perhaps by a multidisciplinary team), and for making decisions regarding the assistance given to the parent. A haphazard handling of calls should be avoided at all costs.

Geographic Service Area. The target area and client population defined for service should match the services the hotline can provide. If service is to be limited to referrals, the hotline can serve a larger population than can one relying primarily on volunteers to personally assist parents who call for help.

There may be a temptation to start with a wide geographic area or a large population, particularly if local services are lacking or scarce. But a new program can easily be overextended. It usually takes several months for a hotline to become known in a community; as word of the service spreads, the number of calls can increase dramatically. If unprepared, the service may find its effectiveness declining. The quality of the service is more important than the size of the population served, especially in the beginning stages of the program. If resources are limited, it is advisable to start with a small service area and to expand as personnel and funds develop.

Organization. In terms of organization and operation, there are three basic types of hotlines: those operated by a parent organization, such as a hospital or protective service unit; those affiliated with another organization; and those that are totally independent. Each type has its advantages and drawbacks.

The primary advantage of a hotline run by a larger organization is its secure source of funding. In addition, the parent organization may offer more credibility for the service with other community agencies and may provide resource personnel and consultants. But there may be a price for these benefits. The parent organization may stipulate rigid management practices, such as in the employment of personnel, and may limit the number or types of services provided. Also, potential callers may doubt the confidentiality and helpfulness of a hotline run by a large organization or a public welfare agency.

Partially or totally independent hotlines enjoy considerably

more freedom. They can set their own operating standards, and can select their own personnel and training methods. Once established, the service may gain even more credibility with the community than the hotline run by another organization. The main drawback to the affiliated or independent service is the almost continual need to write proposals and solicit funding. All the resources needed—from office space and telephone equipment to listeners and other personnel—have to be planned for and budgeted.

While the type of organization is essentially a matter of choice, the various alternatives should be thoroughly investigated before a final decision is made.

Funding. There are many ways to obtain financing, but most demand both time and effort. In general, competition for funds is brisk. Sources of start-up and operational monies include private foundations; various community and business groups that regularly allocate money to social service agencies; and affiliation with a civic group, a hospital, or an educational institution.

Several hotlines have been started on demonstration grants from state and county mental health departments; a few have managed to obtain increases in these grants and to maintain them on a continuing basis. But public funding has its disadvantages, being subject to budgetary cutbacks and annual justifications.

Regardless of how financing is obtained, fund raising tends to be an ongoing activity of any independent service. The task can be handled most efficiently if delegated to a specifc person or group—perhaps to the service's board of directors, or to an auxiliary group that can conduct bazaars and other fund-raising events.

Before prospective funding sources are approached, it will be necessary to develop a budget. Get firm figures on the costs of rent, utilities, insurance, phones, paid staff, consultants, office supplies, and expenses for volunteers if they are to be used. To show that these costs are reasonable, it may be helpful to have the budget of a comparable hotline in hand.

At the administrative level, a hotline must be run like any other business. Responsible accounting practices should be developed early for the income and outgo of funds. It is also important to maintain records of both the number and type of calls received and the services delivered. These records can be used to keep track of cases and their disposition, and will provide valuable statistical data to support fund-raising requests.

Management. It is generally recommended that the administrator of the hotline be a professional such as a social worker or a psychologist. In addition, a decision-making body or advisory group can be extremely helpful. Some hotlines have boards of directors drawn chiefly from their own staffs; others are managed by groups comprising various specialists in case management as well as community leaders. The broad-based advisory group offers two specific advantages: its professional members can provide the service with readily available consultants; and community leaders can be influential in raising funds. One hotline service is considering the establishment of two boards—one to provide professional consultation, the other to manage fund raising.

Type of Service Provided. The decision on the type of service the hotline will provide has to be based on the needs of the community and the number and quality of services already available locally. Connecticut's Child Care-Line provides some telephone counseling along with referrals to appropriate community agencies; the Parental Stress Service of Berkeley, California supplements its referral service with direct in-home work by volunteers, three therapy groups for parents, and a speakers bureau. Other hotlines, lacking sufficient professional backup among their own personnel, have established links with local CPS units, and call on their staffs when needed. County welfare departments providing this type of backup place a certain number of caseworkers on 24-hour call and rotate them on a weekly basis.

As indicated earlier, an initial survey of the community and its existing resources can be invaluable in determining the type of services needed. Here again, there are advantages to beginning conservatively and adding new services as additional funds and personnel become available.

Making Referrals and Using Consultants. Among the prerequisites for success is that the hotline be fully integrated with other community service agencies, particularly the child protective service unit. In order to provide appropriate assistance to callers, an up-to-date referral list of all relevant community services—from mental health clinics, to alcohol and drug treatment centers, to day care centers—has to be developed and maintained. The list should include the names of key personnel, the address and the telephone number of each facility, and a brief description of every service. The administrators of each agency should be contacted for information about the services provided, their criteria for accepting referrals, operating hours, and other relevant matters; in addition, the agencies must be informed that they will be used for referrals.

The real test of how well the service has been prepared comes when community agencies are approached to integrate their services with the hotline. No hotline can survive in a vacuum. The people in other agencies must know and trust the hotline's service if there is to be an exchange of referrals. Agency administrators will probably want to know the professional qualifications of the hotline's staff; the goals, philosophy, and standards of the program; and the types of services that will be offered. Expect tough questions, and do not be surprised if some agency administrators perceive the hotline's services as an encroachment on theirs.

In addition to the referral list, it is important to develop a list of on-call consultants, particularly psychologists and psychiatrists, who are available in emergencies and on short notice. Consultants can be used in various ways: to expedite problem solving, they can be brought in on a telephone conference-call; in an emergency, they may be needed to provide immediate assistance to the parent at home; in a less critical situation, they may agree to see the parent in their office the next day or within a short time. Some consultants may reduce their fees for people with low incomes or may provide counseling over the phone without charge. As noted earlier, some hotlines use professionals from their boards of directors as consultants. This is probably the most effective way to obtain consultants who understand the goals and policies of the service and who are committed to its success.

Recruiting the Staff. A telephone call from an anguished parent may mean life or death for the child involved; the person taking the call must know how to handle the situation responsibly. Whether a professional, a paraprofessional, or a lay volunteer, each staff member must be professionally competent. It is also important that the staff be as permanent as possible to assure continuity of service and to reduce the need for repeatedly training new personnel.

The staff of the hotline deals with parents who typically are isolated, of low self-esteem, and in a period of crisis. In general, the callers need support and friendship, a kind of mothering that will help restore their own self-respect and dignity. The type of personnel hotlines generally seek are mature, compassionate, patient, and able to apply common sense to family problems. Voice tone is important, as is the individual's ability to deal with people in a sympathetic, nonjudgmental way. Preferably, staff members are successful parents who have had the advantage of being raised by a loving family.

Many hotlines employ a combination of key professional social workers, paraprofessionals, and volunteers. The composition of the staff and the personal characteristics of the workers will reflect the philosophy and goals of the service. Choosing the right people is essential, since the success or failure of the hotline will ultimately rest with its staff.

Professionals. Most hotlines hire as their key professionals social workers who are experienced in child protection and mental health and who are familiar with social services in the community. Ideally, they are skilled at training paraprofessional listeners and volunteers, and are able to conduct educational programs for schools and community groups.

The first step in recruiting professional personnel is to design a job application form that will highlight the individual qualities sought and aid in the initial screening of applicants. It is important to consider special characteristics of the population to be served. For example, is it necessary to hire one or more bilingual staff members? Professional consultants might be asked to help develop the application form.

Applicants can be obtained in various ways: through newspaper advertisements, through employment agencies, or simply by informing other service agencies that positions are available. A sufficient number of applicants can often be obtained by word of mouth alone.

The screening of applicants should be professionally and carefully handled. It may be helpful to have consultants in mental health, child protection, and family counseling participate in the screening process. Interview applicants personally as well as over the telephone to gauge how well they will communicate with callers.

Paraprofessionals. Some hotlines employ paraprofessionals, with on-call professional backup, as listeners at night and on weekends; and referral services frequently hire paraprofessionals as full-time employees. The qualities generally desired in the paraprofessional are much the same as for professional workers. Hiring procedures are also similar to those described above, although the screening process may not have to be as stringent.

Volunteers. In most communities, volunteers can be recruited quite easily through community service organizations. However, careful screening is needed if volunteers are to meet the specialized needs of the hotline service. The administrators of one hotline require candidates to complete a very long application form that includes probing questions about their childhood and parenting experiences. With this technique, two-thirds of the applicants requesting the form never return it; most of those who do complete the form pass the screening process.

The volunteer program should be designed with care. Decide exactly what duties volunteers are to perform, and be certain they know what is expected of them. One program requires all volunteers to make a time commitment of one year, including a certain number of hours each week plus two training sessions each month. Volunteers should be kept busy without being overworked. Limit the number to those actually needed.

Training the Staff. A well-planned training program is important. Appropriate training can enable the staff to share information

clearly, can improve telephone-communication techniques, and can enhance sensitivity and awareness.

Training should begin with a thorough orientation to the problem and management of child maltreatment, followed by a specific orientation to the service itself. For example, a reading list of general books and articles could be prepared for trainees, and professionals in various aspects of case management could be asked to conduct seminars for the group. The designers of the hotline could then instruct new staff members in the philosophy and goals of the hotline service.

Trainees must become familiar with the resource files and must learn how to make referrals, when to call in professional backup, when to consult with a supervisor, and how to use consultants. They should also be given firm guidelines on the use and extent of their decision-making power.

Staff can be trained in telephone-listening techniques through role playing—with the instructor playing the part of the parent in hypothetical telephone conversations—and by listening to actual recorded calls. When the trainee is felt to be prepared, he or she can be allowed to take hotline calls with the instructor monitoring the conversations. Complete training may require three or four months.

Many hotlines conduct regular in-service training sessions once or twice a month for the entire staff, including volunteers. While these sessions sometimes consist of lectures by the service's consultants, followed by question-and-answer periods, the time is primarily used for discussion of the handling and progress of actual cases. Through case discussions, administrators are kept informed of the staff's performance, and staff members obtain support and guidance. In planning these sessions, it is helpful to ask the staff what they need in terms of additional training.

Offices. Most independent hotlines operate out of small, central offices. Frequently, the space is donated or made available at a low monthly rate. While the office does not have to be large, it should accommodate desks and filing space for all on-duty listeners without crowding. In addition, it should be relatively free from outside noise.

Some hotlines keep the specific location of their offices confidential for security purposes. But many that are affiliated with or run by other organizations cannot conceal their address. Still others do not regard security as a problem and even provide group therapy sessions at their offices.

Operating Hours. To determine operating hours, one must consider the philosophy of the service; the availability of staff, backup services, and supervision; the operating hours of other emergency services in the community; and budgetary constraints. If there are times when the hotline will not be in service, attention should be given to how the phone is answered. An unanswered phone will hurt the "helping" image of the service; by its nature, a hotline means instant contact between one person and another. If a commercial answering service is used, it should reflect the philosophy of the hotline and provide callers with an alternate emergency number.

The Telephone System. Hotlines can be designed to meet various needs. Since individual calls can last an hour or more, many hotlines covering wide geographic areas have toll-free numbers to eliminate financial barriers to callers. Some hotlines use one outgoing and two incoming lines. Some provide earphones for listeners in order to free their hands for writing and for checking files and resource lists.

The operating hours can influence the design of the telephone system. Some 24-hour hotlines, for example, employ listeners in their homes for night and weekend duty. This requires an extension in each listener's home—an additional expense that eliminates transportation costs to the listeners and allows them freedom about their homes between calls.

Telephone companies can help in designing such systems and in saving money and time. The company may also be able to list the hotline number with other emergency-service numbers in the front of the telephone directory.

Legal Counsel. Before the hotline becomes operational, an attorney should be consulted regarding personal liability with respect to malpractice and false-counseling lawsuits, types of insurance needed to protect the agency and the staff, and in-

corporation of the service. Most hotlines incorporate, usually to obtain tax benefits as nonprofit concerns. However, incorporation should be examined in light of state operating laws.

Confidentiality vs. Reporting. Most crisis-intervention hotlines have built their reputations on the confidential services they provide. The Child Abuse Listening Mediation hotline, for example, receives a large share of its calls from its ad in the "personals" column of the Santa Barbara, California *News-Press:* "Anxious about an unruly child? CALM's confidential listening referral service can help." According to Enid Pike, the director of the service, confidentiality is the reason people call: "We've built up a very strong reputation in the community for keeping information in the strictest confidence, and we tell our callers that we will never use what they say in any way without their permission."

But in most states, the operators of hotlines are included under mandatory reporting laws. They have to draw a line on confidentiality if they learn that a child has been hurt or is in danger. To safeguard the child, they must immediately report these cases as required by law. In actual experience, the need for reporting is rare with self-referral calls.

If a report of suspected abuse or neglect is received via the hotline, the listener must relay it at once to the legally designated agency. Depending on the state, the oral report may have to be followed by a written report. If available, forms for written reports should be obtained and kept on hand.

Hotline operators must be familiar with the provisions of all applicable laws and must institute procedures in line with their legal responsibilities.

Promotion and Education. If it is to reach the parents it proposes to serve, the hotline must be well publicized. Once the line becomes operational, press releases should be prepared and distributed. Radio and television stations will likely agree to broadcast free public-service announcements. A brochure describing the service can be developed and distributed at schools, P.T.A. meetings, churches, supermarkets, and various other places that parents may frequent. Notices can be posted

in laundromats and drug stores and on the bulletin boards of churches, schools, and service organizations. Ads in the "personals" column of newspapers may also be effective.

With the increasing public interest in the problem of child abuse and neglect, many hotlines have created speakers bureaus with the twofold objective of public education and publicity of the hotline service. Members of the staff and the board of directors can appear before community groups, on radio and television talk shows, and as participants in seminars with professionals from other community agencies.

As part of its educational efforts, at least one hotline has found students in junior and senior high schools quite responsive when asked: "What kind of parent would you like to be?" The thrust of the program—which includes the film *The Battered Child,* produced by the National Center for the Treatment and Prevention of Child Abuse and Neglect in Denver—is to make young people aware of parents' responsibility and long-term commitment in raising a child. As one official of the agency explains: "We don't try to dispel the idea that parenting can be a beautiful experience. But we do try to get them to think realistically about their responsibilities and expectations. And we stress that any parent can be a better parent with the proper training."

Evaluation. Regular evaluation of the service and the staff should be carefully planned. Questions such as the following should be examined: Is the service meeting its stated goals? What is its overall effectiveness? What does the service lack? Should some part or parts be eliminated or changed? Are consultants and referrals being used effectively? Is there a need for additional or alternate training? Is each staff member performing in accordance with the goals and philosophy of the service? The answers to such questions are essential if the quality of service is to be maintained and improved.

Telephone Listening Techniques

Every caller to a hotline has a unique set of problems that leads him or her to place the call. Accordingly, it is important that listeners develop techniques to help them learn what makes

the particular caller unique, clarify the situation in the home, and determine what help is needed. The techniques discussed below are examples of some basic approaches to what is sometimes called "creative listening."

The key to being a good listener is to hear and grasp the meaning of what the caller is actually saying. It is often difficult to listen creatively to a stranger over the telephone, particularly if the caller is distraught.

Creative listening begins with assessing the emotional state of the caller and the intensity of the crisis in order to determine whether the child is in immediate danger. In some cases, this is extremely difficult, since many callers will sound calm and rational when they are in fact close to the breaking point. Considerable expertise is needed to determine whether immediate intervention is required. One must listen for clues—the inflection of the voice, pauses, inconsistencies—while asking gently probing questions to draw out the caller's fears and troubles.

Handling the Crisis Call. The caller in the following situation is a woman, so upset she can hardly speak.

"If I don't talk to somebody right now, I'm going to hit my baby again." (She says the word "again" almost inaudibly, but the listener catches it.)

"How old is the baby?"

"Seven months."

"Where is he now?"

"In his playpen."

"Is he feeling all right?"

"Oh, yes. He's making noises to himself. But there's something wrong with me. I have a lot of bad feelings about him. He makes me angry most of the time, and I feel like I'm going to hurt him. I can't control the feeling."

"Did you hurt him when you hit him?"

"No . . . I didn't hit him . . . I said I felt like I was going to hit him."

"Well, what do you think is the reason for your feelings toward your son? A lot of our callers have those feelings and it often helps to talk about them."

*"I don't know exactly . . ."

In this case, the listener would assess the risk to the child as high. The woman probably did hit but did not injure the child. If the listener had tried to make her admit striking the child after she had denied it, the caller would probably have felt accused and might have hung up. The listener was correct in shifting the conversation to the woman's feelings and encouraging her to talk about them. By discussing her frustrations with the listener, the caller is less likely to strike her child again. But since the risk of abuse remains, the listener should suggest some type of treatment, perhaps asking the woman how she feels about joining a mothers' group where she can discuss and be helped with her feelings and frustrations.

If the caller had said under questioning that the child was bleeding or unconscious, the listener would have to provide immediate aid. The listener must be prepared to act quickly in an emergency—to act calmly, keep the caller on the line, and obtain the correct name and address. Once the caller is identified, the child protective service agency or the police can be called. Alternately, if the volunteer is available to make a personal visit to the home, the listener could use the following approach:

"As you probably know, this is a confidential service. But it seems that your baby is hurt, and we really must help him. Let's do this: I'll send one of our volunteer helpers to your house or, if you prefer, I'll come myself, and we'll take the baby to the hospital. Now, this will involve the welfare department (or the police) because the doctors will have to make a report. But I'll stay with you the whole time, and we'll work this out together . . ."

Situations such as the following may occur where it could be unwise to involve the police initially.

"I'm frightened," a woman tells the listener. "I hurt both my children last night. I'm alone with them in a motel room, and I'm afraid I'm going to kill them."

Under questioning, the woman reveals having recently been under care in a psychiatric hospital. Shortly after her discharge, her husband left her. She is now nearly penniless and desperate, alone with the two children, aged two and three. From the way she talks, incoherent at times and sobbing uncontrollably, she appears to be suffering a breakdown.

"You said you'd been in a hospital. Would you like to talk to a doctor?"

"Something is happening to me. I don't know . . . A doctor? What kind of doctor?"

"A therapist. Someone who can help you."

"I feel this terrible pressure on my head. Yes. Yes, I would like to talk to someone . . . here."

"I know how it is to be alone and upset. But we'll get you over this. I'll have a very helpful doctor over to see you in a few minutes. Now, give me the name of your motel and your room number. After I make the arrangements with the doctor, I'll call you back, and we'll talk until he gets there."

The listener had the option of calling protective services or the police to take custody of the children. But the woman could have become more frightened and upset if someone she did not see as a helping person arrived at the door. By getting her to agree to admit a doctor, assuring her that she was about to receive help, and keeping her on the line until the doctor arrived, the listener helped avoid a threatening situation and lessened her distress as well as the risk to her children.

Calming the Caller. It is important to put the callers at ease. The listener should let parents know that they can stay on the line as long as needed and can discuss whatever they want. If the caller is upset or is being interrupted by children, the listener could suggest that he or she get a cup of coffee or, if possible, send the children out of the house. Most important, each caller should be given time to think through his or her problems.

Clarifying Feelings and Options. The listener's general role is that of assisting callers in clarifying their feelings and options. For example, a caller may state: "My new husband seems to resent my daughter. He wants me to spank her for the slightest reason." To help clarify the situation for both the caller and the listener, an appropriate response would be: "Have you and your husband ever discussed his feelings about her? . . . How well do you and your daughter get along when you husband isn't home?" With a caller who says, "I don't feel the same about my kids since my husband left me," the listener could ask: "Do you mean you don't love them as much, or are you worried about carrying the burden all alone?"

Particularly when deprived of meaningful adult relationships, parents of young children often become depressed by the monotony of their lives. They feel "closed in" and can see no means for change. In such cases, the listener can often help make callers aware of available options, as the following examples illustrate:

Caller: *"Before I got messed up with these kids, I was making pretty good money and enjoying myself as a sales representative in a clothing store. I don't see how I could get back there, much as I'd like to."*

Listener: *"Have you thought about placing your children in a day care center? Or, if you'd like, perhaps we could help you find a good sitter. Then you could work at least part-time."*

Caller: *"My son Larry is always hiding from me and won't mind at all. I can't teach him to do anything."*

Listener: *"I know of a mothers' group that holds discussions on child behavior problems. Maybe you'd like to join. If that doesn't help, I could put you in touch with a good child psychologist for your son."*

Preventing "Lost" Calls. Among hotlines' biggest worries are "lost" calls—where the parent reveals a need for help yet refuses to identify him- or herself, hangs up, and never calls again. As a rule, listeners try to obtain each caller's identity so they can send immediate help if needed and can follow up on referrals. Obtaining this information requires patience and skill.

In the midst of an emotional crisis, anonymous callers may talk freely about their personal behavior and their relations with intimates and may admit that they have mistreated their children. But as the conversation progresses and the caller begins to "cool off," he or she may become uneasy about the admissions and may be reluctant to identify him- or herself. To avoid losing the call, the listener must take the initiative. One approach is to swing the conversation momentarily away from the parent and onto the service itself.

"Do you know anything about this hotline service? How it operates?"

"No, not how it operates. I just heard about it and got the number."

"Okay. Let me tell you exactly how we function." (Here, the listener briefly describes who operates the hotline—private citizens, a church group, a welfare agency; discusses the confidentiality of records; and mentions the kinds of services available, either directly or through referral.) "We're here to help you, not to embarrass you or give you any more problems. I'm sure you also understand that if we're going to help, you'll have to trust us and tell me who you are and where you live."

The key, of course, is to gain the caller's confidence. This can often be facilitated by mentioning how the service has helped others. For example: "I got a call last week from a woman in a situation similar to yours. One of our volunteers is now visiting her every day and helping her with her children . . ." One hotline listener tells new callers that some of the parents she works with refer to her as "mother" and that she thinks of them as her children. She has lost very few calls.

Limiting the Call. Some parents become regular clients of a hotline; they call daily, often staying on the line an hour or more, but refusing to discuss substantive issues. Some hotlines never set limits on calls, regardless of frequency. Others find it a problem if the line is tied up by relatively few callers.

There are several ways of limiting excessive calls, such as examining whether listeners are encouraging over-dependence in the callers; establishing guidelines with the regular caller on what is to be discussed; and putting the caller in touch with a worker from the hotline service or another agency, perhaps with a volunteer who can spend some time with the parent each day but who knows how to limit the duration of visits or calls.

With experience, every good hotline listener develops a personal style of listening and responding. Experienced listeners should note the telephone techniques that work well for them and should share their skills both with trainees and with other experienced workers. Helping troubled parents is a skill that can always be improved.

Examples of Hotline Services

The Parental Stress Service of Berkeley, California and Connecticut's Child Care-Line illustrate some of the various functions a hotline service can incorporate.

Parental Stress Service.* A staff member describes the Parental Stress Service and its clients as follows: "Most of our callers are alone and isolated. They don't have a car or money to pay babysitters, and they lack what we call a 'support system' of friends and relatives. They're really stuck. What they need more than anything is a friend, and that's what we try to provide—a helping friend."

The Parental Stress Service (PSS) of Berkeley, California was begun by Carol Johnston, a former abusive parent. Like the parents PSS now serves, she knows the feeling of being alone and isolated and "stuck." While living in a remote part of the state of Washington, she was aware of her need for professional assistance, yet was afraid to seek help.

After moving to Berkeley, Johnston did obtain therapy, and began working for the Alameda County Juvenile Court. There she saw numerous battered and neglected children, and she saw the pain and confusion of their parents as well. From this and her own experience, the idea for a hotline grew—a line any parent could call anonymously to talk to someone who could provide support.

PSS was launched in the spring of 1972 on a $15,000 demonstration grant from the California Department of Mental Health. By 1974, the Service was incorporated into the state mental health program and was receiving double its initial funding. PSS now has two satellite offices in Alameda County, a range of follow-through services in addition to its hotline, and a projected annual budget of $84,000.

In Berkeley, cases of abuse and neglect are handled by the Alameda County protective service unit, the county juvenile court, and the police. But with protective services limited to

*For further information, contact: Parental Stress Service, P. O. Box 9266, Berkeley, California 94709; (415) 845-6243.

welfare families and with parents reluctant, for fear of punishment, to seek aid from the court or the police, PSS has become virtually the only local resource for parents caught up in a crisis with their children.

Its 24-hour toll-free hotline covers all of Alameda County and part of neighboring Contra Costa County. The Service currently receives about 60 crisis-intervention calls a month—70 percent of which are self-referrals—and maintains an active caseload of about 50 families. More than half the client-families are headed by single parents.

Staff. The staff includes eight paid members—a director, an assistant director, an administrative assistant (all professionally trained in social work), a secretary, three coordinators, and a community-outreach worker—and about 60 volunteers. Each volunteer must make a year-long commitment to work four hours a week—answering the hotline or working directly with client-families—and to attend two training sessions a month. Their training is handled by the professional staff and members of the PSS board of directors, which includes child psychologists, marriage counselors, therapists, and a registered nurse.

PSS sets no age limit for volunteers. While the Service has found that experienced parents are most successful, there are some childless people and a few former clients among the volunteers. Administrators of the Service match up each volunteer and client, and volunteers are not given a choice about taking a particular case.

Volunteers are instructed to act as helping friends who assist clients in dealing with their problems and improving their lives. PSS administrators feel their biggest problem is training volunteers to set limits with their clients on the time spent with the parents and the issues to be discussed. Volunteers have to define their role in terms of their own time and energy to avoid overextending themselves and, in turn, rejecting the parent. Yet many find it difficult to restrict their time with people whose needs are great.

Those working directly with clients may provide various services. On occasion, the agency sends two volunteers to a client's home—one to mind the children while the other talks with the

parent. When a parent is sick, in a period of crisis, or going out of town a few days, volunteers may take the children into their own homes, stay with them in the client's home, or take them to a playground for several hours. They may also help parents negotiate with the welfare department and other agencies. While the volunteers do not act as counselors, they do encourage parents to seek psychiatric or other professional help when necessary.

PSS volunteers work under very close supervision and are given continuous support with each case. They frequently discuss the progress of clients with their supervisors, and case discussions constitute a large part of the twice-a-month training sessions. The supervisors also work to increase the volunteers' sensitivity to clients and their awareness of personal feelings that might cause them to reject a client. The volunteers have to be prepared to fight off discouragement when the help they give is not reflected in a client's behavior.

Ancillary Services. In addition to its hotline counseling and volunteer service, PSS sponsors a referral service, three parents groups, and a speakers bureau.

Having integrated its service with other community agencies, PSS repeatedly refers callers and clients to these resources. In return, it receives many referrals from the county family service agency and other local agencies.

Professionals from the staff and the board of directors conduct the three therapy groups for parents. There is one group for single mothers, one for single fathers, and one for couples. The purpose of the groups is to create an atmosphere of trust among the parent members in order for them to discuss and learn to cope with their problems. PSS initially conducted the group meetings on a drop-in basis, but this did not work well. Group members must now agree to attend meetings for at least two months. The parents have responded better to the consistent, well-defined program.

As part of the Service's publicity efforts—which include radio and television public-service announcements, occasional news-

paper articles, and the posting of the hotline number in places that parents frequent—a speakers bureau is maintained. Staff members are on call to speak to community groups about the problem of child maltreatment and the agency's efforts toward prevention.

PSS officials feel the future of the Service is secure. They have not only acquired operational funding status from the state, but they point to the continual increase in self-referral calls as evidence that the Service is filling a real, local need.

Child Care-Line.* A combination reporting and crisis-intervention line, Child Care-Line was set up by the Connecticut Child Welfare Association—a private, nonprofit, citizens' group—as a demonstration project in 1973. Connecticut's reporting law was expanded that year to include virtually all of the more than 100,000 professionals having contact with children in the state. The Association, which had backed passage of the law, saw a need for a 24-hour, statewide communications system to aid in the reporting of cases and to provide a crisis-oriented resource for parents. The line is toll free from anywhere in the state to the Association's headquarters in Hartford.

One reason behind Care-Line was to provide a means of educating professionals about their reporting responsibility and how to make a formal report. But the Association also wanted to demonstrate that existing reporting procedures needed to be improved. The state's Child Protective Services Division accepted telephoned reports from 8:30 a.m. to 4:30 p.m., Monday through Friday, and had no emergency number for evenings, weekends, and holidays. As Jeannette Dille, the executive director of the Association, commented, "The state seemed to assume that children are abused and neglected only during office hours on work days."

Before launching the hotline, Dille surveyed the entire state to avoid duplication of existing services. Although there were a number of hotlines for drug and other types of crisis counseling,

*For further information, contact: Child Care-Line, Connecticut Child Welfare Association, Inc., 1040 Prospect Avenue, Hartford, Connecticut 06105; (203) 236-5477.

there was no statewide network that could be adapted to the problem of child maltreatment.

Care-Line officials feel their service has proved its worth. In its first year of operation, there were 2,359 calls to the hotline, including 255 "crisis" calls. Between the hours of 5:30 and 11:30 p.m., the service received 45 percent of its total number of calls, and 65 percent of those considered crisis calls. Moreover, calls from abusive or potentially abusive parents have been steadily increasing. During a recent six-month period, self-referrals accounted for 16 percent of the calls to the hotline.

Budget. One of four demonstration projects sponsored by the Association, Care-Line was begun on a $25,000 grant from a private foundation. The budget has since risen to $60,000 a year, and there has been some difficulty in obtaining continuing sources of funds.

Among other costs, the budget covers the salaries of three professional staff members, secretarial help, and three paraprofessional listeners who work out of their own homes. The statewide telephone system—which includes three toll-free lines (two incoming and one outgoing) and extensions to the listeners' homes—costs approximately $1,000 a month.

Training and Backup. One of the three paraprofessional listeners is on duty from 4:30 p.m. to 9 a.m. each weekday and 'round-the-clock over the entire weekend. The three are on a four-day rotating schedule, and each is on duty every third weekend. All three are women; two are married and have children. One listener is bilingual in Spanish.

Selected for their ability to deal with people via the telephone, their common sense, and their patience, paraprofessional listeners are trained by the professional staff. With the initial group of listeners, the trainers used hypothetical cases to demonstrate listening techniques and how to obtain needed information from callers. The trainees were also instructed in self-awareness and sensitivity. New listeners are now given some initial indoctrination training, followed by several days in Care-Line's office, where they take actual calls with a staff member at their side. The

trainer listens in on the calls and gives advice on how to handle each.

When on duty in their homes, the listeners have constant professional backup. One of the three professional staff members is always on call and is consulted whenever the listener believes the police or a caseworker should be brought into a case.

Reporting. Care-Line advertises its services through radio and television public-service announcements, a speakers bureau, and a brochure. All its publicity stresses that Care-Line is a non-statutory service, not affiliated with any official agency. However, as professional social workers, the hotline's three administrators are mandated by law to report.

The listeners encourage persons calling with a complaint of child abuse or neglect to report directly to protective services and inform them of how to make the report. The Care-Line staff follows up on such calls to ensure that the report to CPS was made. If, for any reason, a caller refuses to make the report, Care-Line will report if there is sufficient information. Since the reports that come to Care-Line's attention are legally "second-hand" or "hearsay," the service is still trying to formulate criteria for filing its own written reports to CPS.

Care-Line's policy regarding parents who call in themselves is to act as an "informed good neighbor." The listeners respond in a sympathetic, nonjudgmental, nonthreatening way. Self-referrals are not reported to the police or CPS, and callers are encouraged to remain anonymous if they wish. As Marsha Levinson, Care-Line's program assistant, explained: "The real benefit of a citizens' group operating a line like this is that the callers know we are not the police. We've never reported any of these parents to the authorities. We're not willing to sacrifice the trust they place in us by sending in a report. But, without question, if we knew that a child had been injured and we knew where that child was, we would immediately send for emergency protection." According to Levinson, there has been only one self-referred case for which a professional staff member believed a report to CPS was indicated. The listener encouraged this mother to call CPS herself and she did.

Referrals and Counseling. Care-Line maintains a book of referral resources and emergency services in every town in the state. In addition to providing referrals to parents for professional assistance in their own communities, the service is prepared to mobilize emergency protection for an endangered child via an immediate call to the police or protective services.

Professional staff members will also counsel parents over the phone. Levinson, who is a psychologist by profession, notes that the hotline counseling she provides "is not a substitute for ongoing professional help, but it is a half-way measure until we can get the caller to the point of obtaining professional help." She adds that hotline counseling is also a good addendum to treatment, since many of the agencies to which callers are referred operate on an 8:30-to-4:30 schedule. "We act as a buffer in between times. Some people pick up the phone and call us instead of hitting their children."

Even if the hours of the state child abuse register were lengthened, Care-Line officials expect that their hotline would remain in operation. They are convinced of the continuing need in Connecticut for a privately operated, confidential service for troubled parents. As evidence, they cite the increasing number of calls from parents who frankly admit they would never seek assistance from a public agency.

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Chapter 3
Treatment

Of the three components of the community-team program—identification and diagnosis, treatment, and education—treatment tends to be the most notably lacking. It is not uncommon for a community to develop extensive identification and diagnostic resources and then to find itself ill-equipped to help identified families. Even communities with a wide range of therapeutic resources may lack effective alternatives to meet a family's individual needs. More often than not, existing resources have to be modified.

For example, Dr. Richard Galdston, in describing the Parents' Center Project for the Study and Prevention of Child Abuse, notes the tendency of agencies to promote a "treatment technique" rather than to respond to families' needs: "We have had patients who have been picked up by other agencies for day care treatment, night care treatment, job retraining, neighborhood activities, group therapy, psychotherapy, rehabilitation, Montessori training, and psychotropic pharmaco-therapy. In many instances the patients were dropped by the agency involved when it became obvious that the patients' problems were not amenable to or suitable for the treatment offered." [1]

Professionals and agencies that provide therapeutic services have traditionally assumed that "if people want help, they'll show up." This assumption, however, does not always apply to abusive or neglecting parents. For them, the request for help may take a more subtle form—like bringing a beaten or malnourished child to the hospital emergency room. Since these parents are typically untrusting and afraid of being "branded as 'bad' and then hurt by the authorities," [2] they miss scheduled appointments; discourage help; and are generally recalcitrant, hostile, and unresponsive to traditional service methods. In short,

they require "reaching-out" services as well as individualized care.

As Dr. John Reinhart of Pittsburgh's Children's Hospital explains: "You can't sit back and expect these people to come in for help. You've got to go out to them." Therapists, for example, often have to modify their practice "by occasionally seeing the parents at home, chasing them down the hallway, and seeing them at odd times—like two weeks late." [3]

In most communities, modification of traditional resources and procedures—something Reinhart feels "every system has to learn"—must go hand in hand with the development of additional treatment resources. This is the work of the community program's "therapeutic development group"—to encourage groups and agencies to offer innovative treatment programs geared to the needs of families in the community. Its members may, for example, try to "sell" the idea of parent aides to protective services; or speak to a church group about expanding an existing day care program to include crisis nursery facilities; or encourage public schools to offer courses in parenting skills, child development, or family life education as part of their adult education program.

The therapeutic development group functions as a facilitator in initiating and helping set up new programs. Since its members neither operate nor administer these programs, they require no particular qualifications other than "selling" skills. Dr. Ray Helfer emphasizes that therapeutic development is not a job for protective service workers or any other professionals involved in the identification and diagnosis component—"they're too busy putting out fires." [4] On the other hand, Vincent De Francis, director of the Children's Division of The American Humane Association, feels that the development of therapeutic resources is the responsibility of the protective service agency: "CPS is doing this sell job all the time." Whether it is CPS or some other agency, group, or individual, unless someone in the community is responsible for this role, effective therapeutic alternatives are likely to remain in short supply.

Most of the available therapeutic programs that have proved successful share at least three basic assumptions:

- That child maltreatment is a "serious manifestation of abnormal rearing within a family structure" [5]
- That while the child must be protected and the parents given help, the family as a whole must be the prime focus of treatment
- That with present therapeutic techniques, there should be a significant improvement in approximately 70 to 75 percent of all the families entering treatment within six to nine months.[6]

The following sections discuss various therapeutic resources that should be developed, modified, or at least considered by every community program.

Treatment for the Parents*

While no two parents who abuse or neglect their children are exactly alike, the majority share to some degree the following characteristics: a special form of immaturity and associated dependency; tragically low self-esteem and a sense of personal incompetence; difficulty in seeking pleasure and finding satisfaction in the adult world; social isolation and reluctance to seek help; significant misperceptions of the infant; a fear of spoiling children; a strong belief in the value of punishment; and a serious lack of ability to be empathically aware of and to respond appropriately to the child's condition and needs. With the cumulative effect of these factors and the dynamic interactions among them, it is extremely difficult for the parent to maintain equanimity and to be successful in meeting the demanding tasks of child care.**

Parental actions that result in the abuse and neglect of children do not fall into any standard diagnostic category of psychiatric disorder, nor should they be considered a separate psychiatric

*Much of this section has been adapted from the booklet *Working with Abusive Parents from a Psychiatric Point of View*, written by Dr. Brandt Steele for the Office of Child Development in 1974.

**See Volume 1, Chapter 2 for discussion of the personality factors and characteristic traits prominent in abusive and neglecting parents, an outline of the pattern of child care that characterizes maltreatment, and the main factors in the early life of the parents that lead them to follow this pattern.

disorder in themselves. As noted in Volume 1, child maltreatment is a problem of abnormal parenting, a distorted pattern of child-rearing, rather than a psychiatric disorder. This does not mean that these parents are free from emotional problems or mental illness. Among abusive and neglecting parents, the incidence and distribution of neuroses, psychoses, and character disorders are much the same as in the general population. But such psychiatric conditions tend to exist more or less independently of the behavioral patterns expressed in the abuse and neglect of children.

Less than 10 percent of the parents suffer from such serious psychiatric disorders as schizophrenia, serious postpartum or other types of depression, and incapacitating compulsive neuroses. Since these parents may be either temporarily or permanently unavailable for treatment of the more subtle problems of maltreatment, they should ideally be screened from the regular treatment program and given in-patient or out-patient care as necessary. Similarly, those parents who suffer from severe alcoholism, abuse of narcotic and nonnarcotic drugs, or significant sexual perversion or who repeatedly exhibit serious antisocial violence or criminal behavior need much more intensive and prolonged psychiatric care and rehabilitation than the usual child protective program can provide. Until such basic problems have been treated, it is futile to try to alter the parent's pattern of child-rearing. In such cases, it is often necessary to remove the children either temporarily or permanently from the home in order to protect them.

Psychiatric consultation and proper psychiatric screening procedures ensure that the parents will receive appropriate help and that workers will not have to expend time and energy on problems requiring treatment that they are ill-equipped to provide. Working with the seriously disturbed parent should never be delegated to workers in child protective agencies. Not only is this practice unfair to the child, the parent, and the worker, but the results are rarely satisfactory.

In addition to those parents with serious psychiatric and social problems, there is a small but significant number who were abused or neglected in their earliest years and, as a result, suffered organic brain damage due to either head trauma or mal-

nutrition during critical growth periods. Because of brain damage, these parents had perceptual defects, diminished IQ, and significant delay in language development—deficits that may produce in later adult life such characteristics as significant lack of basic knowledge and attitudes of helplessness, immaturity, and dependency. If such organic problems are suspected, careful evaluation through appropriate psychological testing and psychiatric examination should be conducted. Parents who are organically impaired will not respond easily, if at all, to the usual methods of treatment; whereas those whose immaturity and dependency are essentially functional in nature—related to emotional deprivation during childhood—are much more responsive to intervention. If parental dysfunction due to brain damage is documented, therapeutic goals can be appropriately revised and limited, avoiding much unproductive effort by the worker.

Goals of Treatment

Abusive or neglectful behavior is related to a life-long pattern deeply embedded in the parent's character structure. Accordingly, treatment or alteration of such behavior is a difficult and probably long-term project.

The primary goal of treatment is to help the parents replace an abusive or neglectful pattern of child-rearing with a method of care that is both more rewarding to them and conducive to their children's optimal development. Treatment includes reopening channels of growth for the parents in order to help them develop beyond their present limitations and the hampering residual effects of their own early lives. In short, the basic goal is to help the parents become more mature.

Subsidiary goals necessary to the parents' development include building self-esteem; developing basic trust and confidence; learning to make contacts with other people in the family, neighborhood, and community in order to establish personal supports; and developing the ability to enjoy life and to have rewarding and pleasurable experiences in the adult world.

In treatment, parents should learn new ways of looking at themselves, the world around them, and their relationship to that world. Subsequently, they should learn new techniques of

living so as to improve the lives of themselves and their families. Their learning should focus on attaining the ability to try something and, in spite of mistakes, to try again in order to eventually find the most effective technique to gain desired ends. The parents very much need to learn that mistakes are a normal fact of life.

Workers, in turn, must accept errors in both themselves and others and must be ready to give approval and praise for even minimal success. Guidance and education toward improving the parents' ratio of successes to failures is one way of describing the treatment process. The worker is not an indoctrinator but a teacher who makes it possible for the parents to learn.

General Problems and Considerations

Whether they come voluntarily or under some pressure, abusive and neglectful parents usually enter treatment hampered by a set of characteristics that makes the therapeutic relationship difficult. They do not expect to be listened to, understood, nor really helped. Rather, they fear being criticized and punished by workers who will not care about them. As a rule, they have already felt accused or attacked by someone—a doctor, social worker, policeman—who has discovered and described their behavior as abuse or neglect. Thus, in entering treatment, they are reliving a new edition of their life-long nightmare of being criticized and punished for failing to do well.

Particularly in the initial contacts, the worker should bear in mind how the parent must be perceiving the situation. Suspicion and reluctance to become involved should not be interpreted as irrational or "paranoid" behavior but, rather, as the inevitable result of past life experience. In addition, workers should not expect the parent to recognize or appreciate their good intentions. It is not unusual for a parent to question why help is offered or even to ask what the worker expects in return. The worker should not be dismayed if offers of help are spurned.

Some parents are openly angry, argumentative, obstructive, rejecting, and evasive, and their behavior can be an almost insurmountable obstacle to developing a helpful relationship. Often, there is little the worker can do except to wait patiently

without retaliation, trying to find time to be supportive and appropriately helpful.

On the surface, the anger appears to be quite inappropriate and irrational, but it can also be understood as evidence of the parent's attempt to undo the past and work toward a healthier pattern of behavior. In a way, the parent is saying: "I will not be controlled, managed, and interfered with as I was in childhood. I am going to become independent and run my own life." In addition to this element of rebelling against the past and attempting to establish independence, there is also an element of the parent identifying with his or her own authoritative and aggressive parents. In trying to be and act like an adult, the parent simply uses the model of adult behavior learned in childhood. Seeing parental anger in this perspective rather than taking it as a direct personal attack allows the worker to deal with the situation more comfortably and constructively.

These situations can sometimes be lessened or avoided if the therapeutic worker is not active in the reporting or investigation of the family. Those who have been involved in the identification and diagnostic process can then remain the primary target of parental anger, leaving the therapeutic worker a better chance of being seen as a helper. If parents remain severely negative, it may be helpful to share treatment responsibilities between two workers, one to maintain office contacts and the other to make home visits. The participation of two workers may convince the parents that others are in fact concerned about them, while easing the burden for each of the workers involved.

Men are notoriously reluctant to accept help, but the presence of male workers encourages some to accept either group or individual therapy programs. If possible, it is important that both the mother and the father be involved in treatment. Child abuse and neglect is a problem that involves the whole family, even if only one parent actually maltreated the child. As Elizabeth Elmer notes: "[T]here is no such thing as abuse without collusion. Although one member of the family may be the active abuser, his behavior has to be tacitly accepted by other adult family members."[7]

There are some parents who are quite agreeable, docile, and cooperative at the beginning and well into treatment. Occa-

sionally, these are people who experienced relatively little distress in childhood and are able to respond quite readily to an honest, helpful worker who offers some measure of liking and support. But more often, these are parents who learned early in life how to respond appropriately to a situation in order to avoid criticism and punishment. They can perceive what will please others and simply act accordingly.

It is important that the worker not be misled by this superficial appearance of progress. Feeling that the parent's problems are being solved and that the family's life is improving, an unsophisticated worker may end therapeutic contact much too soon, with the possible result of further injury to the children. By maintaining a high index of suspicion, an observant worker can pick up clues to disturbing family situations that may have been glossed over and that make further contact essential. Home visits are a valuable technique for determining these unspoken problems. Here, too, the sharing of treatment contacts between two workers can be quite valuable, since the parent may unwittingly present quite different pictures of family life to each.

Parents who present inadequate or inaccurate information should not be seen as trying to outwit and manipulate the worker; rather, they are more like frightened children, "telling stories that are untrue" in order to protect themselves from being hurt. It is not uncommon for a worker to learn, after several months of treatment, the full story of what happened between the parent and the child. In general, this will only happen when the parent is able to trust the worker. Pressing the parent to tell the truth or to produce facts is, in most cases, probably unwise and pointless. Strenuous efforts in this direction are more likely to produce defensive and evasive maneuvers than useful, accurate information.

For example, as discussed in Volume 1, Chapter 2, the parents tend to have significant misperceptions of their children. Only with great caution should the worker directly confront the parent with the illogic of these misperceptions. Unless the treatment relationship is solid, comfortable, and trusting, the parent is very likely to feel misunderstood, criticized, and accused of being crazy. It is usually more profitable for the worker to use skillful and gentle questioning to help the parents explore the bases of their ideas and to find out for themselves how unrealistic their

perceptions are. In fact, parental misperceptions may not need to be dealt with directly. The parent who is treated with sensitivity and empathy will, in turn, become more empathic. As he views his child with more sensitive awareness of the child's real character, the misperceptions should gradually diminish.

The issue of parental misperceptions becomes complicated when there are real abnormalities in the child. Workers have to understand and deal with "reality" problems differently than they deal with parental misperceptions, even though either may be the basis of the parent's dissatisfaction with the child.

One of the intermediate goals of therapy is to help the parents find more satisfaction in the adult world by overcoming their fear and distrust of people and finding new sources of pleasure. Only after the parent has succeeded in obtaining at least minimal satisfaction will he or she be able to allow the child to experience pleasure. One criterion of success in treatment is for the child to become less restricted and inhibited and to show more pleasurable activity than before.

Another potential problem is that many parents, in obvious need of guidance, may freely ask for advice. To comply directly with this request, the worker not only unwittingly repeats their own parents' mistake of telling them what to do and how to do it, but can also perpetuate their apparent helplessness and lack of self-reliance. On the other hand, by not responding to such requests, the worker repeats another of their parents' omissions: not listening to them and not responding to their thoughts, feelings, or needs. This is a difficult situation, for the worker must listen and show clear understanding of requests, but offer useful support and information rather than controlling advice.

One area in which the parents may request advice involves the handling of crises. A major task for the worker is to help the parents understand the impact of crisis in their lives, and to provide support as they develop new techniques for anticipating and handling crises. The worker must keep in mind that what may appear to be a minor, easily managed problem may be an unmanageable disaster to the parent. The worker's ability to be sympathetically understanding and helpful with even minor crises is sometimes

the first step toward developing a therapeutic relationship with the parent and the beginning of the parent's rehabilitation.

A different kind of problem in establishing and maintaining a therapeutic relationship involves working with parents of a different race or from a significantly different cultural or economic background. In such cases, parents often have a profound distrust of the worker and tend to feel strongly that they will not only be misunderstood because of racial, social, or economic background differences, but will probably be criticized and denigrated as well. Their mistrust can be a significant obstacle that requires much time and patience to overcome. This situation is particularly difficult with a parent who was severely abused or neglected as a child; it resembles and reinforces the pattern of being unable to obtain understanding and sympathy, of receiving only criticism and punishment. The worker will require great sensitivity to separate these two closely allied patterns of distrust —one resulting from the different backgrounds of the parent and the worker, and the other from the parent's childhood experiences. Despite their similarity, the two patterns must be recognized as having different origins and meanings and must be dealt with separately. The most important guideline is for the worker to accept the parent as an individual with a right to personal ideas and to meet the parent on his or her own ground as comfortably as possible.

Effective treatment can be handled by people from many different disciplines and walks of life, using various therapeutic techniques. Special training and experience in a specific professional or paraprofessional field are invaluable assets, but the worker's character and personality are of equal importance. It is useful for a worker to have a nonchalant ability to accept markedly different patterns of human behavior, without having to criticize, control, or manage; an ability to adapt to the parents' needs and to try to satisfy them without being self-sacrificing; some knowledge of child development and behavior; and, ideally, experience in having raised children successfully. Most important, the personal life of the worker has to provide enough satisfaction so that the worker's own self-esteem will not depend on the behavior and progress of the parents.

One of the primary requisites in working with abusive and

neglecting parents is respect for them as individuals. Feeling respected, the parents can learn to respect themselves and can, in turn, more readily develop the ability to be empathically caring for their children.

In addition, workers must be more available than is usually considered necessary in therapeutic work. They must be willing to accept telephone calls or emergency contacts outside of regular office hours, and should never be out of town or unavailable without adequate notice to the parents. To develop and maintain a reliable therapeutic relationship in which the parent is able to trust and depend on the worker, the worker must avoid any semblance of desertion or abandonment. Such a relationship can involve large expenditures of time and emotion for the worker—a fact that again suggests advantages to involving two or more workers with each family in which abuse has occurred. Although some agencies have found this practice to be disruptive, sharing the burden of dependency, anxiety, and responsibility can make treatment contacts easier as well as more effective.

The most valuable ingredients that enable parents to grow and develop are time, attention, tolerance, and recognition of their worth as individual human beings—all of which the worker can provide.

Treatment Modalities

The matching up of parent, worker, and treatment modality is difficult and usually managed on a less than ideal basis. Since the parents are often extremely reluctant to become involved in any form of treatment, the selection of a treatment method may be determined by what the parents will accept rather than by theoretical reasons for a specific choice. In addition, the selection of a therapeutic worker or a mode of treatment is often more influenced by availability than by theoretical ideals. At present, there are no data derived from thorough, comparative studies indicating how or why any one mode of treatment is more effective than another for a particular parent. Yet, even in the face of rather haphazard selection, remarkably good results have been produced by various treatment methods.

By far the greater part of treatment for parents is handled by public and private social agencies in which the traditional values

and methods of social casework are maintained. There is, however, increasing use of other techniques and of paraprofessionals working under supervision. Various therapeutic approaches are discussed in brief below.

Community Mental Health Agencies. A family treatment plan may call for any of a number of mental health services—individual counseling, family counseling, group therapy, play therapy, or psychiatric services. To many families, perhaps most, these services may be either unavailable or economically out of reach, unless there is an active mental health agency in the community.

The mere existence of a community mental health agency does not ensure adequate service. Dr. Lewis Thomas observes that "several decades of Mental Health have not made schizophrenia go away, nor has it been established that a Community Mental Health Center can yet maintain the mental health of a community." [8] Moreover, the availability of the mental health resource does not ensure that the family needing this service most will be helped. Parents having the problem of abuse or neglect rarely seek out mental health services; and it is not uncommon for those referred through protective services or the juvenile court to keep no more than a few appointments.

Respondents to a survey conducted in California included recommendations for "aggressive mental health services reaching into the community to effect prevention as well as treatment." [9] To improve the delivery of mental health services in New York City, the Mayor's Task Force on Child Abuse and Neglect recommended that "social services be considered the most important ancillary (back-up) service available to abusing and neglectful parents who utilize mental health facilities." [10] The Task Force advocated that a caseworker be assigned to each family under treatment by mental health services. The caseworker would maintain close liaison with the mental health facility both to ensure that appointments are kept and to provide whatever services are needed to solve or ameliorate problems that arise during treatment.

One means of providing more active "outreach" mental health services is through a visiting psychiatric service, another recommendation of the Task Force. They suggested that "a staff of home-visiting mental health specialists be developed to treat

those parents whose personal isolation precludes regular office visits." [11] This service could be staffed by various professionals—psychiatrists, clinical psychologists, or psychiatric social workers. The Task Force report indicates that while the cost of such a service would be high, it might be moderate in comparison to the combined "costs" of parents without the help they need—the costs to themselves, their children, and society as a whole.

Psychotherapy. Various modes of psychotherapy have been used in the treatment of abusive parents. Although there has been some success with classical psychoanalysis, the general character structure and life-style of most abusive parents tend to make this procedure impractical and usually unsuccessful. On the other hand, psychoanalytically oriented dynamic psychotherapy, when handled by skilled therapists, has proved extremely successful in many cases.

In general, the therapist must be more willing to adapt to patient needs and to allow greater dependency than is ordinarily considered appropriate. Intensive psychotherapy that skillfully utilizes transference, with avoidance of a full transference neurosis, can stimulate major growth and deep structural change in parents despite their severe immaturity and developmental arrest. The parent tends to respond best when psychotherapy is accompanied by supportive services provided by a child protective service or by individual social workers, lay therapists, or group therapy. Skilled and experienced psychologists can also work successfully as counselors and therapists in both individual and group situations.

Group Therapy. Group therapy has at least one special advantage for parents with the problem of abuse or neglect: it brings these typically isolated people into contact with others. The *Final Report* of the New York Mayor's Task Force comments that "the very structure of the group serves to eliminate feelings of isolation by providing a 'common ground' for peer support." [12]

Parents who have the courage and ego strength to enter a group program can be helped through the process to express their emotions more openly and to learn to accept criticism. As members find out that they are not alone in their troubles, their self-esteem improves. And as they can understand and

respond to each other's feelings and problems, they can have the experience, perhaps for the first time, of trusting someone else and even being able to extend help. In addition, since the therapist works with a number of clients at once, group therapy helps ameliorate the shortage of professionals specifically trained to deal with cases of abuse and neglect.

By itself, however, group therapy is seldom adequate for the person or family with overwhelming social problems, since the therapist cannot provide the social services that may be needed. Moreover, experience suggests that one-to-one contacts outside the group, either with group leaders on an individual basis or with workers from other agencies, are often necessary for the parent's optimal development and improvement.

Most groups are formed and led by professionally trained group therapists such as psychologists, psychiatrists, other mental health workers, and social workers in protective agencies. It is often wise to have at least two leaders, preferably a man and a woman, especially if the group consists of couples.

Since its introduction in 1955, group psychotherapy has been used in the treatment of almost every psychiatric disorder. While its use in the treatment of abusive and neglecting parents is on the increase, there is as yet a dearth of published reports detailing either techniques or long-term results.

Much of the available literature is based on the group therapy program of the Child Trauma Intervention and Research Project at UCLA's Neuropsychiatric Institute. The project is staffed by 10 members of the Department of Psychiatry, five of whom work with the group therapy program. Dr. Morris Paulson, clinical psychologist and principal investigator for the project, describes the group program as "multidisciplinary, multitheoretical, and eclectic treatment of abusive parents through the vehicle of group psychotherapy."[13] The program has been operating for six years and has served some 115 parents to date. There are two separate therapy groups, each conducted by male and female co-therapists. A child psychiatrist and a public health nurse lead one group; a clinical psychologist and a psychiatric nurse lead the other. A psychiatric social worker provides liaison contact with the professional community.

Group members are either referred through the Department of Social Services or the juvenile court, or come through self-referral. Though not required by law to attend, many parents are strongly encouraged. The program insists that both parents attend, if both are present in the family. The intake procedure includes interviews with two staff members and a day-long psychological examination. There is no specified time for termination of therapy. The abused children of group members are generally in foster placement or with relatives, and most of the parents continue to attend meetings until their children are returned. There has been only one recurrence of abuse among the parents in treatment, and this child was a sibling rather than the child originally abused.

The goals of the program are emotional growth, insight, and, ultimately, successful termination of therapy. Initially, the individual parents were suspicious of the therapists. As the meetings progressed, the members of each group increasingly began to trust the therapists and one another, acknowledge their need for help, and place the therapists in the role of parent surrogates. As Dr. Paulson and several of his colleagues note: "For every step toward growth in therapy that could be attributed to the co-therapists, there were ten steps attributable to the group and its members. This was, for the therapists, confirming evidence of the power and the effectiveness of group psychotherapy." [14]

According to Dr. Paulson, many of the parents proved to be "incredibly ignorant of child development; they had no conception of what a three-month-old infant was capable of." The program was therefore expanded to include half-hour sessions dealing with facts about child development and child-rearing. These weekly sessions precede the two-hour therapeutic meetings.

Since many of the parents had problems arranging for the care of their children while they attended group meetings, the program added an in-house "baby-sitter"—a trained worker who also functions as an observer of the children's behavior. Behavioral observation includes notes on how the child separates from the parents, other facets of parent-child interaction, and the child's manner of relating to other children. These data give the therapists valuable clues about the family's progress.

The therapists give their telephone numbers to clients, remain on call 24 hours a day, and sometimes make home visits. As Dr. Paulson explains, these practices help illustrate their philosophy: "When you're panicked, in despair, and have no place to turn, that may be the time when the child is injured. You've got to have a number to call, you've got to have somewhere you can go."

Parent Aides (Lay Therapists). To the parent in need of help, access to psychiatrists, psychologists, and social workers is sometimes limited by waiting lists and often by cost. In many cases, nonprofessionals can help to meet parents' needs. Kempe and Helfer hold that the great majority of parents "can benefit significantly from an intense relationship with a nonprofessional therapist." [15]

Professional opinion is divided on the issue of parent aides. Dr. Frederick Green of Children's Hospital, Washington, D.C., notes that some professionals are skeptical whether "this kind of nonprofessional person dealing with a critical problem may raise issues which he is not capable of handling." But Dr. Vincent Fontana, discussing the parent aide program in Denver, does not seem to agree: "Are there not dangers in letting amateurs venture where perhaps even some psychiatrists may fear to tread? . . . No. The Aides are carefully chosen and work under the supervision of social workers and in consultation with pediatricians and psychiatrists. . . . [T]he entire family structure is carefully evaluated and the parent or parents psychiatrically tested before any sort of therapy is initiated. The ill receive treatment, and the immature get motherly visitors." [16] The New York City Mayor's Task Force suggests that, while lay therapists are inappropriate for use with parents suffering severe psychiatric problems, they can be "highly effective" with the parent plagued by isolation.[17]

There are different concepts of "lay therapists," and variations in the nature of their relationship to the client, the kinds of services they provide, and the intended results. But most such programs are consistent in their description of the parent aide as someone who displays warmth and understanding, who listens uncritically, and offers support. While Dr. Green prefers the term "friend of the family," others describe the role as that of "parenting" or "mothering" the parents.

Ideally, a parent aide is willing to become deeply involved with a family for a period of eight to twelve months or longer; can make weekly or twice-weekly visits during that period; and can relate to the parents from a listening, approving, noncritical point of view, rather than from a position of authority.

The goals of lay therapy are necessarily limited. While parent aides cannot be expected to undo the harms of the past, they can help the parents to a point where the child can safely live at home; where the parents can see and even enjoy the child as an individual; where they can recognize impending crises; where they can ask for as well as offer support; and where, eventually, they are no longer dependent on the primary therapist.[18]

Within the broad concept of lay therapy, various programs have been developed.

Denver. The Parent Aide Program, based at Colorado General Hospital, is staffed by men and women who were raised by loving parents, who are themselves parents, and who are ready to take on the care of another adult. They come from all economic and social groups, and their backgrounds are carefully matched to those of their clients. They work part-time and receive a small hourly wage.

Parent aides informally visit one or both adults in the family once or twice a week. They are encouraged to fit into the life-style of the family—to have a cup of tea or coffee in the kitchen—and to listen with interest to the problems of the parents. Between visits, they are available for help in crises; the client has the aide's phone number and that of an alternate aide. As therapy progresses, they generally begin to function as mature and reliable friends, rather than solely as visiting helpers.

Since parent aides need close and continuing supervision, Kempe and Helfer recommend that they be based in a hospital or other agency that has the necessary professional support.[19] Every two weeks, the parent aides attend a group therapy session where they are encouraged to express to the professional staff their inevitable feelings of frustration, anxiety, and anger. The emotional stress of working with abusive parents makes it necessary to limit caseloads to two or three families each.

One social worker can supervise several parent aides and still carry a limited caseload, which substantially reduces the cost of treatment and increases its availability. Clinical results—provided the initial diagnosis of the family's needs was correct—have been outstanding. Fontana suggests that if "the Aide is successful in establishing a supportive relationship . . . is able to build up the parent's self esteem and sense of personal worth . . . to develop a relationship of mutual trust . . . to ease the parents through crisis situations and truly understand the parent's feelings, then she is not only helping the parents but the entire family and protecting the child in the most effective way possible." [20]

San Diego. Dr. Kent Jordan, with a grant from the California Department of Mental Health, is attempting to implement the Denver lay-therapist model in the San Diego Department of Social Services. In addition, he intends to expand the lay volunteer programs already underway and to develop training materials. The program will eventually include 200 carefully selected volunteer lay therapists, each handling one case, with one client visit per week. As a control group, there will be clients who receive identical treatment except for the provision of the lay therapist. Dr. Jordan hopes to determine, among other things, the characteristics of an effective lay therapist.[21]

Lansing, Michigan. Lansing's Parent Aide Program puts relatively greater emphasis on friendship than on therapy. The 21 parent aides are mostly young married women. According to Helen McGuire, the program's supervisor, they are untrained, but carefully screened: "We look for individuals who have a good marriage, have children with normal problems that the parent can handle, are nonjudgmental and outgoing, and have a capacity for loving people." They are not paid for their work, but do receive expense money.

Working under the supervision of a social worker from Catholic Social Services, each parent aide is assigned one family—usually a multiproblem family that requires more attention that the caseworker can give. Their primary role is that of an understanding friend, needed to break through the family's isolation. In emergencies, they provide services such as transportation or babysit-

ting. Since most of the parent aides are young, they are more like sisters than surrogate mothers to the parents they work with.

Sometimes the parent aide and her husband and children get together with the client-family socially. As Helen McGuire explains, "They're basically free to do anything they want—and they're resourceful."

Arkansas. SCAN (Suspected Child Abuse and Neglect) Volunteer Service, Inc., was organized in Pulaski County, Arkansas by Sharon Pallone in 1972. Her reason for founding SCAN was that not one local agency, public or private, could meet the needs of an abusive parent she knew. Available professional help was fragmented, slow, and generally unable either to meet a crisis or to produce lasting results.[22]

SCAN is currently staffed by 13 full-time employees and about 55 volunteers. The volunteers, mostly women without full-time jobs, provide emergency intervention, as well as long-term counseling and supportive services. Each contributes an average of 20 hours a week and is reimbursed $50 a month for expenses.

The volunteers are carefully selected and given an initial 40 hours of training, conducted by doctors and other community professionals. Among the topics covered in training are medical evidence of abuse and neglect, legal aspects of the problem, marriage counseling, counseling techniques, transactional analysis, and group therapy. In-service training consists of staff meetings every other week and professional consultation as needed.

Under contract with the Arkansas Social Service Division, SCAN receives referrals from the Division, the community, and Arkansas Children's Hospital and cooperates extensively with the University of Arkansas Medical Center. The Service recently expanded from its base in Pulaski County to neighboring Washington, Garland, and Jefferson Counties as a result of a demonstration grant from the U.S. Department of Health, Education, and Welfare (the grant was awarded jointly by the Office of Child Development and the Social Rehabilitation Service).

In all four counties, every report of suspected abuse or neglect is investigated within an hour by a SCAN volunteer. The volun-

teer has no legal authority to remove a child but, through close cooperation with the prosecuting attorney and the Social Service Division, is able to offer the parent the alternative of working with SCAN or facing law enforcement officials and possible foster placement of the child.

Most of SCAN's work consists of "mothering" the parents, thereby teaching them to be better fathers and mothers. The voluntee. focuses on the problems of the parents, providing support and noncritical counseling according to their needs. As Sharon Pallone explains: "The volunteer's work may be as simple as convincing a mother who beat her child because she didn't mop the floor that two-year-olds can't be expected to mop floors. But it may be much tougher—improving housing, getting food stamps or money, arranging for adequate health care. We work with every agency in attempting to solve the problem that spawned the crisis."

The maximum caseload for a volunteer is four families, including no more than two active cases. The volunteers initially spend a great deal of time with each family at home. Their involvement tapers off as the situation improves, although cases are maintained as long as necessary.

Initially, professionals in the community were slow to accept the volunteer organization. But as a result of the skill of SCAN's volunteers—who, since August 1972, have provided service to well over 200 families—the Service has the full cooperation of both the professional community and local government. Eventually, SCAN plans to operate statewide.

Public Health Nurses. Many communities already have a rich resource for therapeutic and follow-up care: visiting public health nurses. Early in the diagnostic process, the nurse can provide the protective service caseworker with valuable information about the family and about the interaction between parents and children. By training and experience, most public health nurses are comfortable entering the homes of clients and talking with them in a relaxed, coffee-in-the-kitchen way. Some, in addition, have a great capacity for caring for the parents of abused or neglected children.

To function therapeutically, the nurse must be noncritical, nonjudgmental, and prepared to commit herself to a deep involvement in the family's life. She should be a sympathetic, understanding listener, rather than an advisor or teacher. The nurse's role is to provide needed "mothering." She should focus not on the child but on the parents, offering them an opportunity to break out of their isolation, to develop trust in another adult, and to raise their opinions of themselves. Without an excess of advice or lecturing, she may be able to help the parents begin to understand and even enjoy their children.

Dr. Morris Paulson and several others from the staff of UCLA's Neuropsychiatric Institute describe why such a relationship can develop: "While both male and female therapists [in their group therapy program] were regarded with increased warmth and consideration, the female nurse co-therapist was much more identified in this surrogate [parent] role. Her information input in the important areas of child development, her practical knowledge in the caring and nursing of the infant and growing child, and her numerous home visits all defined the greater degree of intimacy and personal involvement in the life experience of these families." [23]

If possible, the nurse should informally visit the family once or twice a week—twice weekly at first, then tapering off as the parents progress. It is important that the relationship, once begun, not be cut off too soon. The visits should continue until the child is no longer at risk—preferably for a year or longer if necessary, but seldom for less than eight or nine months. Despite the atmosphere of friendliness and informality, the nurse's visits are an important element of treatment, and a decision to terminate should be made jointly by the nurse, the protective service worker, and any other professional directly involved with the family.

Homemaker-Home Health Aide Services. Homemaker services have been recommended and used as a support to families under stress, as an alternative to temporary removal of the child from the home, and as a way to facilitate a child's return. In addition, homemakers can assume a preventive role, if available to families in which "mothers simply do not have the strength to cope with all the demands of several children." [24] A homemaker who can

fit into the family—not to run the household, but to work along with and support the parents, helping with the house and children as needed—can help relieve at least some of the family's stress.

The exact role of the homemaker varies according to the needs of the family and the goals of the treatment plan. One possible role for the homemaker is mentioned by Paulson and Blake: like the visiting nurse, she can help the social worker evaluate the family strengths and weaknesses through daily observation of interpersonal relationships and patterns of living.[25]

The report of the New York Mayor's Task Force points out that a homemaker who cleans, shops, cooks, and cares for the children can be valuable and even necessary to many families, including those whose children are neglected, and can in the long run decrease the costs of service to the family. But, the report adds, such a homemaker is seldom needed by abusive parents and would be of no help in altering destructive patterns of behavior. The Task Force recommends that the most qualified homemakers be trained as parent aides "to address the emotional rather than the material/logistic difficulties experienced by the abusing parent." [26]

Kempe and Helfer note that the homemaker can be part of the therapeutic team, helping to provide the parents with understanding and emotional support.[27] If the community has a parent aide program, homemakers could be included in their in-service training sessions to gain professional support and advice.

Whatever the role of the homemaker in a family, it should be made clear to the parents from the start. Otherwise, the homemaker's presence may lead to confusion, suspicion, and even greater stress for the parents.

Parents Anonymous. "I started P.A. because of my own problems, because of my own pain, my own anguish." [28] This is how Jolly K., a former abusive parent who had been abused as a child, explains the beginning of Parents Anonymous, a self-help organization for abusive and potentially abusive parents. After repeatedly approaching established agencies for help that she never received, Jolly K. started P.A. as a way to help herself and others.

Today, three and a half years later, P.A. includes some 112 chapters* and approximately 1200 members throughout the United States. Each chapter is headed by a chairperson—a parent from the group—and a professional sponsor who is usually a social worker, psychiatrist, or psychologist. However, as Dr. Vincent Fontana observes, "P.A. does not suffer from any goggle-eyed reverence for professionals."[29] The main emphasis is on parents helping one another.

Members attend weekly meetings at which they exchange family experiences, both good and bad, in a noncritical, supportive atmosphere. Since all the members have experienced the stress and anger that can lead to abuse, they can discuss each other's problems with understanding and without moralization. Parents typically unable to communicate with others learn to share their feelings with the group.

An additional focus of P.A. is on crisis intervention, which typically comes as the result of a telephone call for help. Members exchange first names and telephone numbers. When a parent under stress feels in danger of abusing a child, she or he can call another member, day or night. Help may take several forms: discussion and reassurance over the phone, a personal visit, or sometimes temporary care of the child by another parent. There is a general feeling that giving help—actually being useful to someone in a time of crisis—can be as therapeutic as receiving help.

Since about 80 percent of P.A.'s members are self-referred, some professionals—while lauding the success of the organization—would like to see closer ties between local P.A. chapters and protective service agencies. Protective services could then monitor and be accountable for the child's safety and could provide support services, if needed, while the parents continued with P.A.

Crisis-Oriented Services. As discussed in Volume 1, Chapter 2, crises tend to play a significant role in the lives of families in

*Parents Anonymous has recently received an OCD grant to expand to 200 chapters.

which abuse or neglect occurs. For some families, the crisis may be of a physical nature—the lack of food, clothing, transportation, or shelter. In such cases, addressing the family's physical needs—through, for example, the provision of an emergency loan, temporary housing, or needed clothing—may be an important first step toward treatment, by relieving a stress-producing situation that may have no other solution. Such action may establish the worker as a person who is sensitive to the "real" needs of the parent and can reinforce the parent's feelings of being cared for.

But for many parents, crises are not so much the result of material need as the product of momentary frustration and stress. The breakdown of the television, an argument with one's spouse, the child's breaking of a lamp—these are among the everyday crises that can precipitate abuse. To help both the parent and the child in such a situation, emergency services should be available around-the-clock. These could include a 24-hour crisis-intervention line (see Chapter 2), crisis nursery facilities (see the following section, "Treatment for the Children"), or the telephone number of a worker who can be called at any hour.

Education in Parenting. Treatment that uses cognitive learning techniques is based, at least in part, on the assumption that the parents have difficulty because they have not been given proper opportunity and knowledge to develop adequate parental attitudes and skills. To some extent, this is true; but, in general, the deepest deficit in the parents is in the emotional or affective rather than the cognitive sphere.

Some parents, particularly those who neglect or only mildly abuse a child, may profit from instruction in parenting techniques. But this should not be a standard or exclusive treatment method for the majority of parents. In many cases, even those involving the serious abuse of a child, the parents are able to provide good care for other children in the family. It is evident from such situations that the parents do not suffer a lack of factual knowledge, but rather emotional difficulties involving specific attitudes toward and misperceptions of an individual child.

For those parents lacking child-care skills, classes in a school or hospital or individual instruction by a public health nurse

could be an extremely valuable part of the parents' treatment. Such instruction could include learning how to diaper, feed, pick up, and play with children; how and when to discipline a child; and some facts about child development. The content and nature of the instruction will, of course, be determined by the needs and abilities of the individual parent.

Behavior Modification. Behavior modification techniques—the use of positive or negative feedback to modify behavior—have been found to effect changes in the attitudes and actions of abusive parents in relatively short periods of time. However, it is not clear whether such techniques have validity for long-term rehabilitation.

To some extent, positive reinforcement is an element included in almost all modalities of treatment for the parents. But the use of negative-feedback techniques to induce change has been seriously questioned, even though there has been superficial success with such techniques. Negative feedback is essentially a repetition of the childhood experience of most of these parents, a repetition of the very process that helped lead them to abuse or neglect their children.

Treatment for the Children*

While the care of abused and neglected children has been the concern of health and welfare agencies in this country since the late 1800s, much of the professional emphasis has been limited to medical treatment and physical protection. In many cases, protection has been synonymous with removal of the child from the home. But more and more professionals are recognizing that the child as well as the parent requires direct help if treatment is to produce optimal rehabilitation of the family.

The purpose of this section is to describe several methods of

*Much of this section has been adapted from material written by Elsa Ten Broeck and Steven Stripp for the Office of Child Development in 1974. Many of the points discussed are based on the authors' experience at the Extended Family Center, San Francisco. Except where indicated, the subsection "Removal of the Child" has been adapted from material written by Douglas J. Besharov for OCD in 1975. Much of this subsection is based on the April 1972 Report of the New York State Assembly Select Committee on Child Abuse, of which Mr. Besharov is the executive director.

direct treatment for the very young (up to age five) child. This discussion does not attempt to set treatment for children apart from treatment for parents. While it focuses on children, it emphasizes the family setting, the effects of children's treatment on the parents, and the need to coordinate treatment for all family members.

In this section, aspects of treatment in a day care setting are the primary focus. There are several reasons for narrowing the discussion to this setting: little has been written about therapeutic nurseries; many older children in need of treatment can be referred for individual child-psychiatric services, whereas the very young child cannot; and finally, emphasis has to be placed on providing therapeutic intervention for children as early as possible.

Before discussion of actual treatment modalities, it is important to look at the role of out-of-the-home placement of the child as part of the family's treatment plan.

Removal of the Child

Temporary Removal. Of the many difficult issues in the management of child abuse and neglect, the involuntary removal of children from their parents is among the most volatile. There are some families in which children cannot safely remain. For these families, temporary or permanent removal of the child, accompanied by appropriate treatment for the parents, is the only viable alternative. However, because of inadequate casework and administrative practices, insufficient funding, and lack of trained, experienced workers in some child welfare agencies, foster care—the placement of children with a foster family, in a group home, or in an institution—is the primary mode of "treating" the problems of abuse and neglect in some communities. As a result, some children who could remain in their own homes are placed in foster care, and too many children remain in foster care for too long.

The increasing use of foster placement in recent years has led to a general lowering of standards for recruitment and approval of foster parents. It is a "seller's market," in a sense; more stringent standards, even if they could be enforced, would leave

many children without homes. In some cases, the quality of foster care is not significantly better than the care the children received from their natural parents. There are, for example, cases where foster parents abuse the children placed in their care.

Inadequate record-keeping in some agencies only aggravates the problems of substitute care. One agency, for instance, successively placed and then removed seven children from a foster home is the space of one year. Since there was no record to explain why these children were unable to get along in the home, it was impossible to determine which, if any, children could be placed there in the future.

The child's position in foster care is complicated by policies in some agencies prohibiting excessive emotional involvement with the foster parents. The rationale is that foster care is temporary, the ultimate objective being the return of the child to the natural parents; undue affection by the foster parent could cause emotional ambivalence if and when the child is returned home. When foster parents follow such guidelines—providing a warm home, but a home without too much love—the children often perceive the foster parents as they do their own parents, unable or unwilling to love them enough.

It is not unusual for an agency to remove children from a foster home because they are shown too much love. One agency used this reason to remove two children, nine and eleven years of age, from a foster family in which they were thriving after three years of placement. The children were placed in an institution, and the foster parents brought the matter to court. Nine months later, the case was resolved in the foster parents' favor; but by this time, the children felt so rejected and confused that they refused to return to the foster home. Although both children had an I.Q. of about 120, they remain in the institution where 90 is the average I.Q.

Once the abused or neglected child is placed in foster care, many agencies make little or no effort to work with the natural parents. This is not only dangerous for other children who may remain in the home without services or protective supervision, it also allows foster care to become a more or less permanent situation for the children who are removed. There are, of course,

some agencies that do creative and highly constructive rehabilitative work with the natural parents, but these seem to be exceptions to the typical practice.

Planning for families does not seem to occur in any predictable or reasoned pattern. For example, it is not uncommon for children to be placed in foster homes far from their natural parents. Under such an arrangement, meaningful contacts between children and their natural families are almost impossible, and successful rehabilitation of families becomes unlikely.

In a research project headed by Dr. David Fanshel, director of the Child Welfare Research Program at Columbia University's School of Social Work, 624 children who entered foster care for the first time in 1966 were followed for five years. At the end of three and a half years, 46 percent of the children were still in substitute care.[30] Commenting on their findings, Dr. Fanshel and his colleague Dr. Eugene Shinn write: "It is our impression that too many children slip into long-term foster care careers with the passage of time and their statuses become frozen through a process of default rather than through a consciously arrived at decision that alternatives to placement are not feasible."[31]

This failure to consider alternatives to placement is particularly alarming in light of the often damaging effects of foster care. Even when the quality of care is adequate, placement can be troubling to children. As Dr. Ner Littner explains: "No matter what the realistic reason for the separation, the child seems to experience first—either consciously or unconsciously—a feeling of abandonment, which contains elements of loss, rejection, humiliation, complete insignificance and worthlessness."[32] Foster care places children in a painfully ambiguous situation in which they are unsure of their future. Children frequently blame themselves for the separation from their parents, and they harbor feelings of guilt. If they relate the separation to some fault of their parents, their identification with the parents can result in their seeing themselves as similarly "bad."

The very nature of foster care adds to children's concerns about their worth. Children in institutions may feel "different" because they do not have a family; those in foster homes have names different from the foster family, a constant reminder that

they do not really belong. Eugene A. Weinstein investigated foster children's grappling with four questions: Who am I? Where am I? Why am I here? What is going to happen to me? [33] His findings: these are confusing, anxiety-laden questions for children in foster care; however, children who had more contact and were primarily identified with their natural families showed a statistically greater understanding of their foster placement. These findings point not only to the difficult ambiguities that placement can impose on a child but also to the continued importance of the natural family to the child's well-being.

In 1971, the Davidson County (Tennessee) Department of Public Welfare (DPW) began a three-year project in the metropolitan Nashville area, addressing many of the problems of foster care. The project, Comprehensive Emergency Services for Children in Crisis, provides 24-hour emergency services—including intake, foster homes, caretakers, and homemakers—to enable neglected and dependent children to remain at home or, when removal is necessary, to minimize the traumatic effects of placement. During its first three years, when the project was funded by the U.S. Children's Bureau, emergency placements were reduced from approximately 480 to 70. Funding is now handled by the state and county DPW. In addition, the Children's Bureau is now funding a follow-on project to disseminate information about the Comprehensive Emergency Services program. To date, some 20 communities are committed to installing similar programs.*

Among the recommendations of the Massachusetts Committee on Child Abuse were four suggested components of an adequate foster care system: the 24-hour availability of "highly competent professional foster homes"; a mechanism for recruiting, reviewing, and supporting "good quality" foster homes; the innovative use of day care; and the development of alternative group care facilities. These recommendations are based on the assumption that, when placement is unavoidable, foster-home care "is often preferable" to and "less expensive" than institutional care.[34] In a foster home, a child should receive temporary but uninter-

*For further information, contact Patricia Lockett, Director of the National Center for Comprehensive Emergency Services, Nashville Urban Observatory, 320 Metro-Howard Office Building, 25 Middleton Street, Nashville, Tennessee 37210; (615) 259-5371.

rupted care, while his or her parents are in treatment or until permanent placement is arranged.

Foster parents often pride themselves on taking better care of a child than the child's natural parents. This feeling—while it is gratifying for the foster parents and helps to compensate for poor pay and long hours—can further disrupt the natural parent-child relationship by reinforcing the parents' poor image of themselves. However, through careful selection and professional support, foster parents can be a source of help for the natural parents as well as for the children. The following example illustrates the supportive and therapeutic role the foster parent can play.

Throughout the investigation and court hearing, Erica maintained that she did not know the cause of her five-month-old daughter's severe injuries. She felt that the psychiatrist and the social workers who were assigned to "help" her were unfair and insensitive, and she was not able to benefit from the contacts. Her daughter Jennifer had been placed in a foster home, which Erica avoided because she was afraid of what the foster mother would think of her. Her husband Tony did not visit either, feeling little attachment to the baby and no responsibility for her care.

*Erica finally decided to visit her daughter; she worried that by staying away she would be thought an unfit mother. To her surprise, the foster mother was quite sympathetic. She talked with Erica about the baby's behavior, not about what Erica "had done." The foster mother sewed a kerchief for Erica and occasionally invited her and Tony for meals. She encouraged them to bathe Jennifer and to take over other parental tasks, which not only helped them to feel close to the baby, but also relieved the foster mother of much of Jennifer's care. As soon as possible, Erica and Tony were allowed to take the baby home for short visits. These visits gradually lengthened until the child was permanently and safely returned.**

*Adapted from material written by Elizabeth Davoren for the Office of Child Development in 1974.

Permanent Removal. Unlike Erica and Tony, some parents of children in foster care will never have the interest or capacity to care adequately for their children. In cases where the child's return is unlikely, the possibility of adoption should be actively explored.

Freeing Children for Permanent Placement is a project begun in Oregon in the fall of 1973 to deal with the problem of children remaining in foster care, often for years, because alternatives to "temporary" placement had not previously been explored. Funded by the U.S. Children's Bureau, the project began by identifying children in foster family care who had little chance of returning to their natural homes, and by examining their files to determine if an honest effort had been made to work with the natural parents. Treatment services were then provided for those parents who seemed likely to be able to respond. In the project's first year, over 10 percent of the children in the study population were returned to their natural homes; others were adopted by their foster parents; and, for others, adoptive homes were recruited. The project—which covers 10 of the state's high-population counties and a sampling of rural counties—is also working to educate judges and attorneys about the importance of freeing children for adoption when there is little possibility of their return to their parents.*

In recent years, adoption has become possible for an increasing range of children; those who are available for adoption now stand a better chance of finding a home. There are several reasons for these changes. Because of more widely practiced birth control and the legalization of abortion, and because more unwed mothers now keep their children, there are increasingly fewer unwanted children. Interracial adoptions and the adoption of older children have become more common as the number of white infants available for adoption has decreased. In addition, subsidized adoptions have lessened the financial burden to families with limited incomes.[35]

Nevertheless, many child welfare agencies rarely, if ever, consider adoption as an alternative for children in their care. In the

*For further information, contact Victor Pike, Project Director, Freeing Children for Permanent Placement, 1415 S.E. 122nd Street, Portland, Oregon 97216; (503) 257-4344.

Fanshel study, less than three percent of the 624 children in foster care were adopted in the period of three and a half years.[36] Many smaller agencies are simply unequipped to handle adoptions. In one case, although the foster parents wanted to adopt the child and the natural mother agreed to terminate parental rights, the agency did not know how to go about the adoption process. Other agencies refuse to assist in adoption proceedings on the grounds that their attorneys' time is not reimbursed.[37]

Even after the decision to terminate parental rights, adoption can be torturously slow. New York City's Department of Social Services studied time variations in the adoption process, using a sample of 274 children from 19 agencies.[38] The time between a child's placement with an agency and completed legal adoption ranged from 13.4 months to 28.1 months, with an average of 22.1 months. The mean interval from placement with an agency to placement in an adoptive home was approximately eight months. This study is of interest not only because it shows the adoption process to be unnecessarily lengthy, but also because the time variations among the 19 agencies indicate that the quality of management can prolong or expedite the process.

The adoptability of a child can be greatly influenced by the length of the adoption process. Prospective adoptive parents generally prefer infants. Although this preference is becoming less rigid, it still limits the possibility of adoption for children over three or four years of age, particularly for minority-group children. More important, a lengthy adoption process places children in a kind of limbo in which they are denied consistent mothering in their formative years. Judge Nanette Dembitz of the New York Family Court warns that "children are kept in foster care for year after year after year; if finally by the age of seven or ten or twelve the mother has completely abandoned the child, it is too late—and frequently the child is too maladjusted or too involved in juvenile delinquencies—for adoption."[39]

There are at least two specific mechanisms that could facilitate the adoption process. First, since some agencies avoid adoption in favor of prolonged foster care because of such expenses as legal fees, private welfare agencies could be reimbursed for the costs involved in terminating parental rights and placing a child

for adoption. Second, laws could be enacted authorizing the juvenile court to immediately free children for adoption when, in Judge Dembitz's words, "the possibility of the mother's ever being able to give the child decent care is zero or very, very slight."[40]

Treatment Modalities

Within the last decade, a variety of services for abused and neglected children has been developed to supplement in-home treatment services for the family. The intent of these services is to support the child's expression of feelings, to meet the child's emotional needs, and to offer direct treatment.

Play groups generally meet a few hours a week, often while parents are attending therapy sessions. Frequently staffed by volunteers under the supervision of a professional, the play group has as its major advantage the opportunity for diagnostic observation of the children.

Crisis nurseries offer immediate relief to parents who are temporarily unable to care for their children. The primary functions of the crisis nursery are to protect the child and help stabilize the home by providing the parents short-term relief from child-care responsibilities.

Therapeutic day care centers have several important functions. From four to ten hours a day, the center functions as a refuge for the children; and is a support to treatment for the parents vides diagnostic observation of and intensive, long-term therapy for the children; and is a support to treatment for the parents by allowing them the needed time to develop and pursue other interests.

Family shelters offer intensive 24-hour residential care for the entire family. Such comprehensive treatment provides an ideal setting for intensive diagnostic study and 'round-the-clock intervention. Residential treatment is usually limited to a few months, followed by out-patient supervision. An example of a family shelter is the Temporary Shelter at the New York Foundling Hospital.[41]

Behavior Characteristics and Dynamics

Brief contact with abused and neglected children has led to descriptions of placid, slow-learning infants and overly friendly preschoolers who form indiscriminate attachments to adults. These descriptions support the opinion that the children, though quiet or overly friendly, are generally "normal." But through long-term daily contact, this initial "normal" and, in particular, "good" behavior can be seen to be only one of several defenses against the very troubled environments in which maltreated children develop.

In day care settings, abused children have displayed a variety of behaviors that are noticeably different from those of other children of the same age and in similar settings.[42] The abused children evaluated in one study were found to be four to eight months behind their peers in language development.[43] In general, the children's coordination skills, both gross and fine, are less developed than would be expected for their age; those who are mobile tend to be accident-prone. As a group, abused children are sick more often and for longer periods of time than infants and preschoolers in other group settings.

Their behavior tends toward extremes of introversion or extroversion. The degree to which the children were abused seems to be in alignment with both their symptoms and their responsiveness to treatment. When abuse is severe, the children tend to display extremely introverted symptoms; when abuse is mild, they tend to display a variety of extroverted symptoms soon after the first week in a center.

Introverted symptoms include passivity, withdrawal, inhibited verbal or crying responses, and immobility. Extroverted symptoms include hyperactivity, very short attention span, and seemingly unprovoked aggression. The initial symptoms of the introverted children tend to resolve into more varied repertoires of behavior within the first three months in a center; for the extroverted group, the initial behavior changes may occur in a few weeks or less. In general, children who are initially timid and passive eventually begin to express more anger and defiance, while those who are initially aggressive and hostile gradually begin to express sadness and fear. Timid children who originally require a great deal of

physical holding become more willing to explore on their own, whereas those children who at first cannot tolerate physical contact begin to allow it.

Even after children have attended a center for several months and some of their initial behavior has changed, certain characteristics remain. For example, separation is difficult, from parents in particular; and transitions in general are very threatening. Arrival at the center is a difficult time of the day. Although many of the children overtly seem to have no fear of leaving their parents, they express their attachment-anxiety nonverbally once they are in the center. It is not unusual to find children climbing over or hiding under tables, hanging on to the front door, walking aimlessly around the room, or refusing to take off their coats.

For many of the children, resistance to change continues throughout the day. Daily events, even those occurring with regularity, are continually resisted until the children begin to develop trust and become willing to take risks. Nap time can be particularly difficult. The children tend to be very tense and unable to relax. They resist confinement in a bed or crib and become upset and fearful when restrained. Despite their resistance, most of the children do need a nap; and, with individual attention and physical contact, they do fall asleep.

Another prominent characteristic is the children's unusual propensity for violence.[44] Many respond with aggression to anxiety, threats, and confusion. It is not unusual to observe a toddler, who is unable to join in a game, simply destroy the game rather than accept exclusion. Many of the children express violence even without provocation. Destructive behavior tends to be characteristic of those who have suffered chronic anger and rage from disrupted rapport or trust with their parents. These children are often vulnerable to tantrums and rage as well as to destructive acts when confronted with the limits and discipline of the center.

Some children in treatment have displayed well-developed skills at frustrating and provoking both adults and other children. Those who have experienced chronic shame and fear—by being disciplined through name-calling and required to perform beyond

their age and developmental capabilities—tend to humiliate and terrorize other children. Those who have suffered chronic distress—by having satisfaction of their needs delayed or only partially met due to negative parental feelings—often seek to frustrate others.

Periodically, some of the more severely abused children exhibit autistic-like behavior. They appear to desensitize themselves to certain auditory, kinesthetic, and visual stimuli. In a conversation, these children listen and respond; but when being disciplined, they refuse to acknowledge or respond to their own names. They sometimes collide with objects, as if the objects did not exist. And despite frequent accidents, they exhibit no signs of pain and seem to have only a hazy awareness of their physical environment. Much of this desensitization is believed to be defensive behavior developed to cope with the physical pain these very young children experienced early in life.

Treatment Considerations

A center for abused and neglected children needs to offer the nurturing and care most children receive at home; in addition, it has to help the children develop skills to cope with the above average demands of their homes. Two goals of treatment are for the children to develop their ability to trust and to develop positive self-images. Both can be reached more easily if the therapeutic environment gives the children a sense of safety and positive feedback.

It is important to create a personal space for each of the children, a space where each is reminded of his or her unique identity. A picture of each child in his or her part of the room is helpful; and mirrors, particularly small hand-mirrors, are not only interesting to children, but help them initially in developing their self-images. Such measures can help the children develop a positive sense of themselves that will allow them to maximize their ability to grow and develop.

A consistent routine helps the children perceive the center as a "safe" environment where they can test feelings and actions and begin to trust themselves and others. To facilitate the development of trust, the staff should be consistent in their actions

and should always prepare the children for transitions through verbal explanations. It is important to verbalize even routine transitions, such as feeding and changing. This technique is particularly helpful with the nonverbal child and has encouraged speech in children who are old enough to talk but who have previously remained nonverbal.

Verbalization between the staff and the children can also help the children recognize and deal with their feelings, particularly feelings of rage and terror. Once the predominance of these negative feelings lessens, the child can begin to learn to deal effectively with the environment.[45]

The center's program must also teach the children how to deal with various settings and surroundings and how to obtain satisfaction from a variety of sources. The children quickly learn that certain behaviors and expressions which are denied them at home are allowed in the center. Abused and neglected children learn, at an earlier age than most, the reality of contradictions in life and the types of adjustments they must make. Without extensive longitudinal research, it is impossible to assess the effect of this knowledge, at such a young age, on children's emotional growth and development. Nevertheless, it is clear that unless the children are removed from their parents, they must learn to cope with some degree of emotional trauma.

A side benefit of all day care programs is that they expose preschool children to adults who can supplement parental care. This exposure helps children realize that there are adults other than their parents who can provide for their needs. The sharing of parental responsibilities, including child care and nurturing, is a basic principle of the extended family. The re-establishment of this principle can be an effective means of assuring the physical and emotional survival of the maltreated child.

A therapeutic environment in a day care center, coupled with intensive parent treatment, is often the most effective means to help the children maximize their development. Without having to endure the trauma of total separation from their parents, the children can learn the coping skills needed to minimize the negative effects of remaining in a home where their emotional needs are not completely met.

Planning a Center

Following is a list of some practical considerations in planning a therapeutic day care center.

- Choosing a population

  (1) Determine the age group of children to be served.
  (2) Develop, designate, or coordinate with programs to provide treatment for the parents of client-children.
  (3) Determine the types of cases to be served—whether preventive, suspected, or identified.
  (4) Develop a referral process.

- Choosing a site

  (1) Become familiar with all federal, state, and local codes relevant to group child care, such as welfare, fire, or health department codes that will impact on particulars of the age group to be served, required indoor and outdoor space, required plumbing, required isolation space, required access to the building and yard, and needed renovations to the existing building.
  (2) Obtain zoning requirements needed to establish a day care center in the chosen site.
  (3) Evaluate the site in terms of transportation to and from the center.
  (4) Evaluate the available space in terms of future requirements. For example, in a long-term program, more space will be needed when infants reach the toddler stage.
  (5) Choose a site that includes adequate separate space within the center for parents to meet with each other and with the staff. Preferably, there should be enough space to accommodate groups of parents.
  (6) Apply for and obtain all licenses required by state and local laws. Be prepared for delays in processing such applications.
  (7) Negotiate a lease with an open-ended option to renew.

- Equipping a site

  (1) Spaces that should be created include a space for isolating disruptive children, a space where children can express aggressive feelings, and a particular space

that helps the child feel safe and not overwhelmed by emptiness or overcrowding.

(2) Suggested equipment and supplies include:

(a) Strong durable toys that can withstand great amounts of physical attack yet cannot be used as weapons.

(b) Equipment that allows for the expression of feelings, such as barrels (for hiding); pounding boards; large foam-rubber blocks; musical instruments, especially drums and bells (careful supervision is required with these); a record player and records; dolls and a doll house; a television cabinet (without the picture tube or the accompanying electrical equipment) that the children can use for dramatic play; dress-up clothes; and toy kitchen equipment.

(c) Equipment that encourages group play, such as a water table, a rocking boat, a sand box, a three-foot-wide slide, and an auto-tire swing.

(d) Equipment that encourages active play, such as climbing boards, climbing structures, tricycles, and a padded tumbling area.

(e) Equipment that encourages verbalization, such as books, records, blocks, and a fish tank (properly anchored and carefully supervised).

- Suggested daily routine

(1) Arrival

(a) Greet the parents and children.

(b) Put coats and personal belongings away, allow for the expression of separation feelings (verbal and nonverbal), and prepare for breakfast.

(2) Breakfast

(a) Preparation: set the table (the children's participation should be encouraged), toilet the children, help them to wash their hands.

(b) Eating: allow for messiness, but take precautions to protect the children's clothing; stimulate conversation about home and the day ahead.

(c) In cleaning up, the children's participation should again be encouraged. Toilet the children after breakfast.

(3) Morning activity
   (a) Include group activity to encourage peer relationships, activities to help children in individual areas, and activities to enhance development skills.
   (b) Where possible, allow for simultaneous group and individual activities with staff available for both.
(4) Lunch
   (a) Preparation (same as breakfast).
   (b) Eating (same as breakfast).
   (c) After cleaning up, prepare the children for their naps.
(5) Nap
   (a) Preparation should include outside activity to release energy, preparation of the sleeping area, toileting, quiet time with books and puzzles, verbal preparation, and individual physical contact such as rocking and patting to encourage relaxation and sleep.
   (b) Waking up should be followed by toileting, then music or quiet activities.
(6) Afternoon activity should include free play out-of-doors, supervised group games, and individual use of space.
(7) Departure
   (a) After toileting, have children's personal items together and the children cleaned up prior to their parents' arrival.
   (b) Verbally prepare the children for departure.
   (c) In greeting the parents, ask about their day and inform them of the events of the child's day.
   (d) Give support to the children as they leave. If necessary to aid in the transition, allow a child to take something from the center home.

Staffing

Staff Selection. The selection of appropriate staff is the most crucial ingredient in a successful program. Although all the characteristics of a successful teacher cannot yet be defined, limited experience shows that a teacher should have good health and

stamina; be patient, flexible, and consistent; have a cheerful disposition; and, most important, have special sensitivity for both the child and the parent. It is a rare and valuable teacher who can give the needed emotional support to the children and still support and empathize with the parents.

The teacher must perform many parental functions—such as showing the children tenderness and affection, and setting reasonable limits—and must often help the child cope with instances of parental rejection, resentment, inappropriate expectations, and even brutality. Yet, at the same time, the teacher must be sensitive to the parent's ability to nurture the child and must be willing to turn that responsibility back to the parent. The center must create an environment where the parent and the child can relate on a level that provides for the maximum growth of each.

When interviewing prospective teachers, questions such as the following should be asked:

- How would you handle a parent who is angry because you allowed his child to behave in a manner that the parent does not allow at home?
- Do you feel that the needs of abused children differ from those of children who have not been abused? If so, how do they differ?
- How would you handle the following situation in the center: a child, in front of her parents, tells you that she doesn't want to go home?
- What would you do if a parent began to spank her child excessively in front of you in the center?
- How would you, as a teacher, discipline a child in the center?
- How would you respond to a three-year-old in the center requesting a bottle at nap time?
- What would you do if a parent refused to allow you to do certain things for his child that you felt were important to the child's development?

Staffing Patterns and Support. The required child/staff ratios

of traditional day care agencies—4:1 for infants, 5:1 for preschoolers[46]—are not adequate to meet the physical and emotional needs of abused children. Working with abused children requires total involvement. They frequently need individual attention, and they require constant supervision. The work can be physically and emotionally exhausting.

Day care personnel traditionally schedule breaks and staff meetings during nap time or scheduled group activities, times that usually allow for low staff/child ratios. In therapeutic day care settings, however, these are the times of greatest tension for the children. The budget should permit enough supplemental help to provide the full-time staff with relief, planning time, and meeting time away from the children.

Faced with limited resources to hire the needed full-time staff, the typical therapeutic center must use volunteers and part-time help. For example, the Extended Family Center in San Francisco has successfully used two mentally retarded adults in the infant-center program. Other alternatives for providing supplemental care include using high school students and neighborhood youth groups; college students majoring in education, nursing, or social work; and senior citizens. A large staff offers the additional benefit of allowing the children to relate to a number of adults who give them consistent nurturing.

Ideally, the staff should include both men and women of a wide range of ages and of various ethnic backgrounds. If possible, one or more staff members should work exclusively with the parents. In addition to maintaining a large corps of part-time and volunteer help, it is important to provide the full-time staff with ongoing training and ways to handle their own inevitable frustrations.

Therapeutic Interventions and Games

The staff of the Extended Family Center uses specific interventions and has developed games to help the children begin to recognize and deal with their feelings and alternative forms of behavior. Several examples follow.

Therapeutic Interventions. Preverbal infants may exhibit rage

and tantrums through uninterrupted crying or lack of responsiveness to holding, feeding, burping, and changing. These behaviors are often the result of repeated force-feedings or being ignored when quiet or crying. Appropriate interventions include gentle rocking in an automatic swing, singing, feeding in a feeding table with a large tray, or encouraging feeding by allowing natural exploration with soft, colorful food such as fruit cocktail.

The verbal child may exhibit rage through tantrums or destructive acts. Such rage may be the result of the parents' anger with the child's expression of needs or their arbitrary interruption of the child's pleasurable activities. For the verbal child expressing rage, several types of intervention are: consistent verbalization of limits; forceful verbalization of unacceptable destructiveness; encouraging both the "injured" child and the aggressive child to verbalize anger; acknowledging the child's fear of rejection; and giving the child space to have a tantrum, then encouraging him or her to rejoin the group once the tantrum is ended.

As a result of parental anger and threatened punishment in reaction to a child's expression of needs, the child may exhibit symptoms of withdrawal: passivity, immobility, meek crying, or extreme shyness with adults and children. Appropriate interventions would include: establishing a protective environment for the child; one-to-one, adult-to-child contact; holding, rocking, and eye contact; singing; and encouraging the child to explore various objects.

Finally, for children who terrorize others through unprovoked threats, taking toys from other children, taunting, or risk-taking, several interventions can be used: consistent and appropriate setting of limits, encouraging the child to verbalize feelings, or offering the child alternatives to these behaviors. Such actions are often the result of either parental expectations that the child perform beyond his or her ability, or repeated criticism and threats.

Dramatic Play. Games based on dramatic play should first be practiced by the teaching staff, then introduced to a few children at a time. Usually, the teacher will go through the dialogue and action two or three times, leaving appropriate pauses, until the children gradually respond and imitate. Slow, clear dialogue and

consistently repeated actions facilitate the children's learning. Some children may simply watch for a time before joining in.

The following dramatic play, "The Glum Ghost Lives in the Zeon Pit," is particularly helpful for children who exhibit rage and tantrums.

Introduce the game by asking the children:

"Do you want to play 'Glum Ghost'?"

Teacher: "This is what the Glum Ghost says:
'I'm busy being busy, being busy.'"
(This is said while pointing in the air and turning in a circle.)

Teacher: (Points at one of the children.)
"Don't you laugh!"

Repeat; this time going in the opposite direction. After some practice, employ the "Cloze" technique and omit the word "laugh." The children generally supply the word with glee.

Teacher: (After two circular walks.)
"Where does the Glum Ghost live?"

Teacher: (Stooping.) "Wa, down, down, down *in the* Zeon Pit!! *And what do you hear from the Zeon Pit?"*

Teacher: (In a whiny, angry tone.) "I want to be happy yesterday! I want to be happy yesterday!"

Teacher: (Stands slowly while mimicking a pair of glasses with his/her hands and looks at each child.)
"Are you in the Zeon Pit? . . . No, you're smiling . . . Are you in the Zeon Pit? . . ."

Children enjoy this game and frequently ask to replay it. Some of the parents have borrowed it to play with their children at home. The game can be used as a treatment technique when employed at the anticipation or onset of a child's tantrum. The teacher can use the hands formed as glasses to clue the child's memory of the game. Next, the teacher can say: "You're falling into the Zeon Pit! When you're through being miserable, come join us."

"Poor, Pity-Me Parrott" is a dramatic play for children who

exhibit withdrawal; it is particularly effective for children who exhibit chronic anxious imitation of others.

> *Teacher: (Arms folded to simulate wings; head rolled in a bird-like gesture.) "Awrrk! I'm not here! Awrrk! I'll do what you do . . . maybe you'll like me!"*
>
> *Repeating the phrase, walk backward until hitting a wall.*
>
> *Teacher: "Ouch! Why did I hit my head? Oh, why? Oh, pity me!"*

Many children play and replay this game with laughter for relatively long periods of time. Those who enjoy it often ask their parents to play "Glum Ghost" as well.

For children who terrorize others, the dramatic play "Stupid Stick" is especially useful.

> *Teacher: (Holding a stick vertically.) "I'm all alone. I don't need help! Forward march!" (Begin moving backward.) "I'm all alone. I don't need help!" (Back into wall and hit head.) "Ouch! It's your fault! It's your fault!" (Mimic striking someone next to you and end game with:) "I'm not a stupid stick. Are you a stupid stick?"*

The play can be used as an intervention by asking a child who is threatening another if he or she is a "stupid stick."

Implications for Parental Treatment

Therapeutic nurseries are best offered as one component of a comprehensive treatment program for the family.[47] Direct care of the child can, in fact, create additional problems for the parents and should not be offered unless some type of supportive treatment is available.

For example, one of the classic symptoms of abusive parents is an often extreme need for nurturing. Unless the parents receive individualized treatment, they often resent the care and treatment their children receive. It is pointless to create a positive environment for a child eight hours a day only to have him or her return each evening to jealous and resentful parents.

Treatment for the children can also have a negative impact on

the parents' characteristically low self-esteem. A parent's sense of inadequacy tends to increase when the child enters therapeutic day care. The mother and father typically interpret the referral to the center as an illustration of their failure to be "good" parents. Feelings of inadequacy are most often expressed through resistance and hostility toward the center's staff; the parents tend to be critical of the care the child receives and appear to rejoice when staff members make mistakes. Even parents who seek help voluntarily tend to resent the staff because competent professionals make them feel more inadequate.

Although threatening, therapeutic day care is a valuable service that offers tangible help to the parents. Many parents, in fact, seem to "dump" their children on the staff, and frequently forget or even refuse to come for the children in the evening. These reactions generally reflect the parents' inability to tolerate the dependency of the child; they diminish as the parents' own dependency needs are met in treatment.

Another advantage of the therapeutic nursery is that it offers parents the opportunity to see their children in a group and to begin observing them and their behavior in a new way. The nursery is also an ideal setting for parent education programs staffed by workers trained to deal with the special needs of parents. Timing is a primary factor in the success of parenting education: the parents can use information on child development and child care only when they are ready to nurture their children, and this occurs only when their own needs begin to be satisfied. At this time, the parent will usually ask voluntarily for needed information about the child's development. Parents who continually reject solutions to their child-care problems may simply be stating that they are not yet ready to deal with the child.

In treatment, there is sometimes conflict beween the needs of the child and the needs of the parent. The following case is an example.

> *Elaine was three months old when diagnosed for fractures of the jaws, ribs, and extremities resulting from abuse. After seven months in the home of relatives, she was returned to the custody of her parents on the conditions that she be*

placed in day care at the Extended Family Center and that her parents participate in the center's parent-treatment program.

Initially, Elaine was extremely withdrawn. She would not move unless picked up by a staff member, and she rarely cried. When handled by an adult, she became fearful and whimpered quietly. Nap time was most difficult. Despite all attempts to help her relax, Elaine rarely slept. The only object that gave her comfort was her bottle.

After the family had been in treatment for about four months (Elaine was then 14 months old and just beginning to walk), her mother demanded that the staff no longer give the bottle to the child. For about a week, the teaching staff and social workers at the center discussed with the parents the child's need for the bottle. But the mother remained adamant that Elaine was old enough to be weaned. She felt that the center was spoiling her daughter: "It's a hard world, and it's time for Elaine to learn how to be tough in order to survive." The mother and father, concerned whether they as parents could control the care of their child, finally threatened to remove Elaine from the center if their expectation was not met. After conferring with the center's consultant, the staff reluctantly agreed not to give Elaine a bottle at nap time.

There are no specific guidelines for these situations other than to warn of their existence and to note that it is important for the staff to be aware of the entire family's needs and to consider both the immediate and the long-term consequences of all decisions. In the case described above, it was decided that insisting on the child's having the bottle would result in the parents' rejection of treatment; this would place Elaine at a greater risk than was warranted by the consequences of depriving her of the bottle. Such conflict situations can sometimes be avoided if staff members respect the parents' opinions about the care of their children and allow them to air concerns and grievances.

A related problem that must be anticipated when planning a family-oriented center is the potential conflict between staff

members who work with the parents and those who work with the children. Such conflict easily develops unless definite times and procedures are designated for communication between the two groups. Exchange of information among all therapeutic workers is essential for understanding both the children's and the parents' behavior and for offering appropriate, consistent treatment.

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Chapter 4
Education and Training*

Education and training is the third essential component of the community-team program. Like the identification and diagnosis component and the treamtent component, education and training is essential to a community program's success. The development of educational programs can involve any of a number of people and groups—an educational specialist from the community mental health center, the department of social services, a university, or the school system; professionals skilled in working with groups; someone experienced in the production of audio-visual presentations; an advertising agency; or groups such as the League of Women Voters or the Junior League. The work of these people—the education component of the community team—falls into four basic areas: education of the public; education of professionals who deal with children; the training of those directly involved in cases; and public relations. Their efforts will determine, at least in part, the effectiveness of case management in the community.

Public Education

Children are abused in the privacy of the home. Their families are typically isolated from friends and relatives; and neighbors, not wanting to become involved, may simply ignore a child's screams, scars, or neglected condition. As late as 1966, one authority, Elizabeth Elmer, wrote of the "social taboo" surrounding child maltreatment: "We resent the evidence that vindictive impulses exist in others and may therefore exist in ourselves. Hence, the 'cloak of silence' and the determined actions to eliminate or disregard the evidence." [1]

*Adapted from material written for the Office of Child Development in 1974 by Deborah Adamowicz and Donald Depew, Brandegee Associates, Inc.

As long as people are reluctant to accept the reality and seriousness of child maltreatment, children in need of protection are likely to remain at risk, and parents in need of help are likely to remain isolated with their problems. The public needs to be informed that abuse and neglect can occur in any neighborhood and in any family. They need to understand the necessity of reporting their *suspicions* that a child may be at risk. They have to be informed about the procedure for making a report. And, most important, they need to be familiar with the types of services available to families with the problem of abuse or neglect.

Dr. Vincent Fontana suggests an additional focus for public education: public awareness of the problem of maltreatment should include awareness of the need for people to reach out—in a personal, caring way—to isolated families. Public education could perhaps include promotion of "the idea of neighbor helping neighbor or running next door to offer coffee and sympathy."[2] This focus would not only clarify the "helping" aspect of the community's approach to cases of maltreatment, but might also help to prevent the abuse or neglect of a child.

This level of knowledge and awareness in the general public might well be the object of a long-term educational program. In the shorter term, a brief but intensive information campaign can sensitize the public to the problem. There is evidence that public information programs can have a tremendous impact on reporting. Florida, for example, conducted a statewide, total-media public information campaign from October 1972 through December 1973. During the first 12 months of the campaign, there was an increase of more than 200 percent over the previous year in the number of reports phoned in through the state's reporting line. In total, more than 29,000 reports were received during this period. A discussion of the Florida campaign, including guidelines for conducting a public information program, is presented later in this chapter.

Professional Education

Doctors, nurses, social workers, teachers, and all other professionals who work with children need more extensive information than the general public. Many professionals are unaware of their

legal responsibility to report suspected cases. Others, though aware, simply fail to report for any number of reasons or report only the most extreme cases.

Professional education, like public education, can take various forms. For example, a manual—including general social and physical characteristics indicative of abuse and neglect, legal responsibilities, and reporting procedures—could be developed and distributed to professionals locally or statewide.

Short-term courses and seminars could be held for professional groups in the community; perhaps these could be included as part of the in-service training programs teachers, social workers, and other professionals are required to attend. Sympathetic professionals could be enlisted to address professional meetings. A well-known physician or the head of a state agency, for instance, could address local meetings of the medical profession, emphasizing both professional considerations and the legal obligation to report. A lawyer might be asked to address groups of professionals to explain the legal aspects of the problem. Or members of the community program could speak to various groups about the extent of the problem locally, the services available in the community, and how they as professionals can help.

University departments of medicine, law, social work, nursing, and education could be encouraged to include in their curricula general information—or even specific training—on the detection and handling of cases of abuse and neglect. Professionals from the community program could help design these curricula and might even arrange to speak to classes or conduct seminars for the students. In addition, state licensure boards and pediatric specialty boards could be encouraged to include on professional examinations questions on the problem of child maltreatment and the state's reporting law.

Professional Training

Professionals directly involved in case management require specific training on their roles and responsibilities. For instance, protective service caseworkers and police officers have to learn, among other things, how to evaluate a home in terms of the child's safety. Physicians and others sharing diagnostic respon-

sibilities have to be trained on the specifics of their roles. And those involved in treatment—from psychiatrists and psychologists, to homemakers and parent aides—need to be instructed on how to work with the families.

While specific information on roles and responsibilities will vary with the particular discipline or agency, the general content of training workshops could include discussion of the psychodynamics of child maltreatment, recognition and diagnosis of the problem, interview techniques, legal aspects, involved community agencies and their functions, and the roles and responsibilities of all professionals participating in case management. To encourage interdisciplinary cooperation, various professionals could jointly conduct workshops for different groups. For example, members of the Los Angeles Police Department's Abused and Battered Child Unit attend an intensive, eight-day training program that includes speakers from U.C.L.A.'s Neuropsychiatric Institute, the Children's Hospital, and the Department of Public Social Services. If people qualified to direct such training are not available locally, professionals from diagnostic consultation teams, child protective services, and community programs in nearby cities or states may be willing to conduct seminars and workshops in the community.

Training in the practical aspects of case management should be supplemented with regular meetings focused on the emotional aspects of the job. Elsa Ten Broeck, director of the Extended Family Center in San Francisco, explains: "Child abuse hits at the most personal level, and creates incredible anxieties. It's hard to deal with people who can injure or kill a kid. To be successful, you have to deal with your own anxieties and emotions. As we, as professionals, begin to support and deal with each other on a more real basis, services will improve."

Public Relations

Public relations activities are a natural outgrowth of educational programs. Public awareness of the community-team program will likely generate interest among laypeople and professionals as well as increase community involvement in the program. But members of the program's education component should also take specific steps in the direction of public relations.

The press should be kept informed of program accomplishments and activities—the establishment of a protective service unit or a parent aide program, notices of symposiums, or the creation of a crisis-intervention "hotline." Members of the program should try to obtain the support of local professional associations, and should actively seek to involve both professionals and interested laypeople.

Fund raising is another obvious PR activity. Members of the program will have to obtain funding for the salary of a program coordinator, the expenses of volunteer parent aides, the salaries or expenses of members of a speakers bureau, and various other expenses. But, as discussed in the guidelines in Chapter 5, fund raising for the program should not be attempted until the three program components have been established and the members of the community team are able to work together smoothly.

Public relations might also focus on legislative activity. In Montgomery County, Maryland, for example, members of the Executive's Task Force on Child Abuse promoted legislative revisions which were subsequently included in the state's child abuse statute (see the appendix). In addition, community leaders should make legislators on the local, state, and national levels aware of the problem of child maltreatment and the need for appropriations for programs and trained staff.[3]

The kinds of public relations work a community program undertakes, like every other facet of the program, will be determined by the needs and resources of the community.

The Florida Public Information Campaign

The following pages describe the brief, but intensive public information campaign conducted by the state of Florida from September 1972 through December 1973. While Florida's program is not necessarily the ideal model for all public information efforts, it is a good example of one state's success in heightening public awareness about the problem of child maltreatment. This discussion is presented as a case study that illuminates some of the methods, the problems, and the possible impact of a coordinated, statewide information campaign.

Although it was not the first state to make a public information effort, the Florida campaign was outstanding in its scope and quality. Florida had already initiated a statewide protective service program; a toll-free, 24-hour telephone system for reporting; and a central register to receive, relay, and store information about reported families. The statewide, total-media campaign was intended to enhance these existing resources. It had two principal objectives: to increase public awareness of the problems of abuse and neglect; and to inform the public of an easy means for reporting. In practical terms, these objectives came down to one goal: to make the reporting line ring.

Before the Campaign

Between September 1970 and September 1971, 17 reports of abuse and neglect were filed in Florida's "central register," a small box in the Jacksonville office of the Division of Family Services (DFS). This box was the only statewide record of reported cases. At the time, both reporting and investigation were handled through local juvenile courts, whose personnel were instructed to notify DFS of all reports received. But because the system lacked coordination, most reports never reached Jacksonville, and it was not possible to obtain an accurate, statewide picture of the incidence, reporting, and management of abuse and neglect.

Like reporting, child welfare services were uncoordinated on a statewide basis. In 1970, only 27 child welfare units operated in the state's 67 counties, and only three areas within the DFS organization had specialized protective service units.

Florida's approach to managing abuse and neglect began to change in 1970, when the legislature took the position that the state, rather than the counties, should have overall responsibility for child welfare services. The next year, several legislative changes enabled the Department of Health and Rehabilitative Services (DHRS), of which DFS is a part, to begin building a statewide protective service program.

One of these changes was the revision of the state's Child Abuse Act (Section 828.041, Florida Statutes). Previously, only doctors and other medical personnel were mandated to report abuse, and there was no requirement to report neglect. Under the

amended act, effective July 1971, doctors, nurses, teachers, social workers, and employees of any public or private facility serving children are required to report suspected abuse or neglect directly to DHRS, which is to investigate all reports immediately. The act also called for the Department to establish a central register as part of its overall mandate "to protect and enhance the welfare of abused children, and . . . other children potentially subject to abuse [when] detected by a report . . ."*

During the same legislative session, the Juvenile Court Law (Section 39, Florida Statutes) was also revised. As part of the amendment, the Division of Family Services was given specific responsibility for dependent children, with DFS personnel authorized to take a child into temporary protective custody if the child is in immediate danger in the home.

As a result of these legislative changes, DFS issued a Statement of Intent on June 29, 1971, which provided that DFS would administer the Child Abuse Act; establish a centralized reporting system; coordinate a protective service program for the entire state; and conduct a statewide, public-service publicity campaign. According to Geraldine Fell, assistant chief of the Bureau of Children's Services, DFS, "The main difference in protective services since 1971 is that, for the first time, protective service workers are located in each county in the state, making services available to children and families 24 hours a day, seven days a week."

In October 1971, the Division set up a central register and telephone hotline—called the Florida Child Abuse Registry Wide Area Telephone System (WATS)—as the core of a statewide reporting and investigative system. When the hotline system was first installed, thousands of letters explaining the reporting procedure were sent to Florida professionals mandated to report. Follow-up postcards and telephone stickers with the WATS-line number were sent within a month of the beginning of operation. Several newspaper editorials on abuse and neglect and the state's reporting system appeared at this time, in addition to occasional news releases issued by the Division. Although the system re-

*Under the legislative definition, the term "abuse" includes neglect and failure to provide sustenance, clothing, shelter, or medical attention.

ceived no other publicity, 19,128 reports of abuse and neglect were entered in the register the first year; 4955 came in through the WATS line, and 14,173 through the local DFS offices.

The Campaign

With the hotline system in operation, DFS initiated plans for the statewide information campaign required by its 1971 Statement of Intent. In mid-1972, the Division retained Franceschi Advertising, Tallahassee, to produce the public-service program.

The Concept. The advertising agency's proposal was to blanket the state for a period of one year with high-quality materials for television, radio, outdoor advertising, and newspapers, as well as collateral items.

Their original concept was to capitalize on the shock value of abuse. They felt that pictures of abused children or models made up to appear battered—children with bandaged heads, scarred bodies, blackened eyes, and broken arms—with "Stop Child Abuse" as the campaign's theme, would command their audience's attention. Initially, the DFS staff liked the concept. But after further consideration, the agency reversed its opinion and rejected the idea. They reasoned that the public was being so saturated with violence by the news media that further exposure to brutality might "turn off" the people they wanted to reach.

After several more creative sessions, the agency developed the concept of using pictures of healthy, appealing children to contrast with the headline "Who would hurt a little child?" This question became the campaign's theme.

Basically the same headlines and body copy were used for all media. Alternate headlines were "Who would . . . murder, rape, starve, torture, burn, neglect . . . a little child?" The copy answered the headline question, briefly explaining the problem in Florida, and stressed the need for reporting. Each piece of copy ended with the toll-free WATS number, followed by one of two tag lines: "You could save a young life" or "Lift a finger to save a child."

Since all media were to be used, continuity of theme was

essential. Duane Franceschi, who supervised production of the campaign, believes that repetition of the theme among the various media helped reinforce the campaign's message: "The ideal situation would have been for a person to hear a radio spot while having breakfast, to see a billboard while driving to work, to notice one of the ads in the afternoon paper, and then to see a public-service spot on television that evening. This was the kind of reinforcement we hoped for. We didn't expect anyone to copy down the WATS number after seeing or hearing one of the ads. We simply wanted to make people aware that child abuse is a reality and that there is a reporting number available."

Samples of Campaign Materials. The samples reprinted here illustrate how the campaign's theme was carried throughout the different media. Following are scripts for two of the 60-second radio spots, the first introduced by original music written for the campaign. In all, nine radio announcements of different lengths were produced.

MUSIC: *Hold the children in your arms . . . Only you can keep them safe and free from harm . . . Keep them warm . . .*
(Under)

ANNOUNCER: *Who would beat a little child? Last year thousands of people throughout Florida did.*

They beat them, starved them, tortured them, raped them, neglected them . . . and even murdered them.

These parents are sick. And their children need help, desperately.

Now you can help. If you know of a case of child abuse, call us toll free, any time, day or night. Call Child Abuse, 800-342-9152 . . . You could save a young life.

MUSIC: *Only you can keep them safe and free from harm . . . Keep them warm.*

ANNOUNCER 1: *Here are some numbers we think you should know:*

ANNOUNCER 2: *Sexual abuse . . . 523. Beatings . . . 2,663. Medical neglect . . . 1,115. Abandonment . . . 844. Unattended . . . 4,541. Broken bones . . . (Under)*

ANNOUNCER 1: *This is not a casualty list for Viet Nam . . . It's a list of actual reported cases of child abuse in Florida. Last year, over 19,000 children were beaten, battered, burned, raped, starved, tortured, neglected, and murdered.*

ANNOUNCER 2: *Dead on arrival . . . 13.*

ANNOUNCER 1: *Who would hurt a little child? You'd be surprised!*

If you know of child abuse, call this number, any time, day or night, toll free . . . 800-342-9152. You won't have to get any more involved than a phone call . . . 800-342-9152. You could save a young life.

The following television scripts were used for two of the six professionally produced color spots. The first is a 30-second announcement; the second runs one minute.

VIDEO	AUDIO
Open on extreme close-up of little girl sobbing. Slow pull back to reveal she is sitting on bed. Camera very selectively pans on girl.	*Who would rape a little child? Last year, throughout Florida, there were over 400 reports of children who were raped by a parent.* *If you've never thought much about child abuse before this, we hope we've got you thinking now.*
SUPER: Call Child Abuse *800-342-9152* *You Could Save A Young Life.*	*If you know of an abused or neglected child, call us toll free at 800-342-9152, any hour, day or night.* *You could save a young life.*

VIDEO	AUDIO
Two-frame quick cuts of children's heads.	*SFX: Computer noises.*
	ANNOUNCER 1: Here are some numbers you should know.
Numbers super over children. Total changes with each new number.	*ANNOUNCER 2: Broken bones . . . 149. Beatings . . . 2,663. Sexual assaults . . . 523. Unattended . . . 4,541. Neglected . . . 1,115. Abandoned . . . 844. Disorganized family life . . .*
Freeze frame on last child.	*ANNOUNCER 1: Last year throughout Florida there were over 19,000 reports of abused children. And remember, these are not just statistics . . . they're children. Here's another number you'd better know.*
SUPER: Call Child Abuse 800-342-9152 You Could Save A Young Life.	*If you know of an abused or neglected child, call Child Abuse toll free at 800-342-9152, any hour, day or night.*

The copy samples below were used, respectively, in full-page and small-space newspaper ads.

WHO WOULD HURT A LITTLE CHILD?

In the last year, thousands of people throughout Florida did. They beat children, burned them, starved them, raped them, neglected them, tortured them mentally, and murdered them.

These people are sick.

These children need help. Desperately.

What can you do?

We're working on the theory that somebody knows about almost every child who is abused or neglected.

If you're that somebody, it's important that you tell us. You don't have to get any more involved than making a phone call.

Call Child Abuse toll free any hour, day or night at 800-342-9152.

As soon as we hear from you, we'll act. If a child is in immediate danger, we'll take it to safety. If the parents of the child need help adjusting, we'll arrange it. The important thing is we can't help unless we know about it.

So if you know of an abused or neglected child, or, if you have feelings of uncontrollable rage toward a child, call us.

Who would hurt a little child?

You'd be surprised.

CALL CHILD ABUSE: 800-342-9152

You could save a young life.

WHO WOULD MURDER A LITTLE CHILD?

Last year throughout Florida, there were 13 child abuse cases that resulted in death.

Maybe you could have stopped them.

If you know an abused or neglected child, call us toll free any hour, day or night.

CALL CHILD ABUSE: 800-342-9152.

Lift a finger to save a child.

The copy for posters prepared for distribution to professionals was essentially a shorter version of the full-page newspaper ad. There was only one significant change: after the final question, "Who would hurt a little child?" is the line "Do we have to remind you?"

Costs. The production of these materials required almost six months. It has been estimated that if the agency had charged regular commercial rates, the cost of producing the campaign would have been close to $100,000—twice the amount they were paid.

Professional advertising is expensive. For instance, the televi-

sion materials alone cost some $20,000 to produce. Production units were hired to do the radio and television commercials, and a songwriter was contracted to write music for some of the spots. All the children pictured in ads were professional models, and only professional radio and television announcers were used. In addition to a creative director and a writer brought in from out of state, eight members of the advertising agency's regular staff worked on the campaign.

Franceschi, whose background includes work in television and radio, feels that such professionalism is essential in any public-service campaign: "We wanted to be sure we did it properly, particularly since we were planning to use donated media time and space. I've found that if radio and television stations are given a good-quality, professionally produced, public-service announcement, they'll use it."

The cost of media time and space for the statewide campaign, if purchased at then-prevailing rates, has been estimated at $2 million. To buy 30 seconds of prime time on television, for example, would have cost from $900 to $1400 at 1972 rates. Public service was obviously the only feasible way to run the campaign.

Distribution. In September 1972, with production completed, a brochure explaining the campaign and the importance of media cooperation was mailed to all newspaper publishers, outdoor advertising companies, and radio and television stations in the state. The media were asked to use the campaign materials throughout 1973. Three days later, complete public-service kits containing the ready-for-use materials followed.

In addition to the media publicity, DFS arranged to have Girl Scouts deliver 50,000 campaign posters to professionals including doctors, nurses, teachers, social workers, and day care workers throughout Florida. The Division had earlier begun arrangements to have the state's 16 telephone companies list the WATS-line number in their directories, both inside the front cover with other emergency numbers and in two places in the white pages—under "Child Abuse Registry" and "Florida, State of, Child Abuse Registry."

Media Exposure. To ensure the widest possible media exposure, each medium was given a choice of materials. For example, some radio spots were developed for stations with a "top 40" music format, some for "easy-listening" stations, others for talk shows. Each included 10-, 30-, and 60-second versions. Newspaper layouts ranged from full-page to one-sixteenth-page ads. For television, there were six different spots, with 20-, 30-, and 60-second versions of each.

As Franceschi explains, each medium was able to adapt its use of the materials to the space or time available: "We knew that television stations, for example, wouldn't use a 60-second public-service announcement in prime time when blocks of 20- and 30-second units are sold. So we shortened our 60-second spots for prime time use. The longer versions, we knew, could gain fringe time."

Although no formal follow-up was used to determine the extent of media exposure, Franceschi feels that television was the most effective medium for the campaign; outdoor, second; and radio, third. But he was disappointed in the relative lack of cooperation from newspapers: "Several college papers did publish the full-page ad, and several weeklies the small-space ads. But I never saw nor heard of a major daily using an of our material."

He gave several reasons for these differences in time and space donations: "Radio and television stations are required by the Federal Communications Commission to set aside part of their programming for public service. This was a great help in getting our material on the air. And outdoor advertising companies, though not required to grant free space, will post a public-service message on an unrented unit for 30 days, provided they've been given the poster paper. Newspaper publishers, on the other hand, rarely donate space." Unlike the other media, which have a certain amount of time or space to be filled, the length of each issue of a newspaper varies with its content. If a radio or television station has a 30-second unit that has not been sold, they will use a public-service spot to fill the time. But newspapers have little excess space; extra space can easily be filled with news or editorial copy.

Though the campaign had officially ended, some announce-

ments still appeared well into 1974. Both the advertising agency and the DFS officials are pleased with the widespread exposure campaign materials have received. As Mary Ann Price, a consultant to Florida's protective service program, commented, "There's not a region in the state that hasn't reported coverage of the campaign through radio, television, or outdoor ads."

Effects of the Public Information Campaign

The campaign's effects have been basically two: it has contributed to increased reporting; and the greater volume of reports has increased the caseload for DFS personnel.

Increased Reporting. The main goal of the campaign had been to make the Child Abuse Registry WATS line ring. For the year-long period beginning October 1972, which included 12 months of the information campaign, 52 percent of all reports came in through the WATS line. The total number of reports had increased 55 percent over the previous 12 months—from 19,128 to 29,686—and reports called in through the WATS line had more than tripled. (Figure 2 shows a breakdown of results by reporting periods; Tables 1 and 2 present complete reporting figures.)

The public information campaign unquestionably had an impact on statewide reporting, and it did in fact make the WATS line ring. Unfortunately, the campaign's impact cannot be measured precisely, since callers were not asked what prompted them to report or how they learned of the WATS-line number. To evaluate its effect, it may be helpful to examine several explanations that might account for the dramatic increase in reports during the campaign.

The increase in reports could reflect an actual increase in the number of incidents of child abuse and neglect. This explanation seems highly improbable. There is no other evidence of a 55-percent increase in child maltreatment in one year. Some small increase might have occurred, but this would account for only a minor rise in reports. It seems far more likely that many of the reports were based on pre-existing conditions or on incidents that had occurred previously but had not been reported. This would indicate an increase in public awareness and willingness to report.

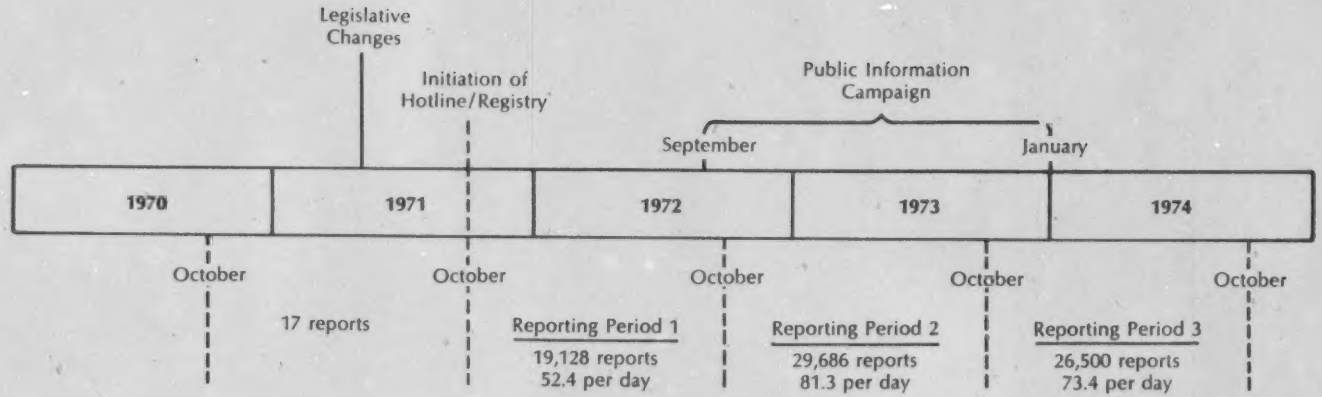

Figure 2. Time line showing a breakdown of reports by reporting periods.

Table 1
Volume of Reports

Reports	Reporting Period*					Cumulative (as of 9/26/74)
	1			2	3	
	Oct.-March	April-Sept.	Year's Total			
Total	*3,615*	*15,513*	19,128	29,686	26,500	75,314
Receved through WATS Line (Number)	*610 (approx.)*	*4,345 (approx.)*	4,955	15,375	15,350	35,680
Received through WATS Line (Percent)	*16.5*	*27.5*	26	52	57.5	47

*Reporting periods are: Period 1—October 1971 through September 1972
Period 2—October 1972 through September 1973
Period 3—October 1973 through September 1974

Table 2
Reports by Type of Abuse or Neglect

Type of Abuse or Neglect Reported	Reporting Period*					Cumulative (as of 9/26/74)
	1			2	3	
	Oct.-March	April-Sept.	Year's Total			
Dead on Arrival	3	9	12	10	8	30
Death Due to Injury	2	5	7	8	8	23
Sexual Abuse**	103	398	501	819	796	2,116
Skull Fracture	9	21	30	33	46	109
Broken Bones	17	44	61	115	131	307
Cuts	13	59	72	185	264	521
Burns	24	81	105	218	220	543
Bruises	79	401	480	1,368	1,842	3,690
Beatings	493	2,109	2,602	4,715	4,889	12,206
Malnutrition	41	160	201	258	320	779
Medical Neglect	206	864	1,070	1,765	1,738	4,573
Disorganized Family Life	764	2,900	3,664	9,235	5,409	18,308
Abandonment	222	585	807	1,081	985	2,873
Unattended	642	3,596	4,238	6,396	6,103	16,737
Lack of Food, Clothing, Shelter	520	1,681	2,201	2,234	2,371	6,806
School Problems	186	492	678	701	626	2,005
Other	265	1,933	2,198	492	479	3,169
Unknown	26	175	201	53	265	519

*Reporting periods are: Period 1—October 1971 through September 1972
Period 2—October 1972 through September 1973
Period 3—October 1973 through September 1974

**Includes rape and other abuses.

The increase could be attributed to increased reporting on the part of professionals required by the state's amended Child Abuse Act to report suspected abuse and neglect. Although this explanation could apply to the initial 12 months of the state's reporting system (Reporting Period 1), it seems to have had little effect on the increase during much of the campaign (Reporting Period 2). In fact, the greater part of this increase in reports did not come from professionals, as Table 3 shows, but from neighbors, relatives, and others who may be termed the "general public."

The minimal increase in reporting by professionals does not necessarily indicate lack of concern. For example, reporting by social workers actually declined in the second reporting period—probably not because of any slackening in effort, but because more people were reporting directly to Jacksonville rather than channeling their reports through social workers. There are perhaps other reasons that explain the small change in the volume of reports from professionals.

In any event, the point is clear that the greatest increase in reporting has come from the general public, which was the primary target of the information campaign.

Finally, it is probable that many of the reports are traceable to Florida press coverage of several sensational cases of abuse during the early operation of the hotline and register. It is hard to believe that reports of child torture and editorials on the problem of abuse in Florida could have failed to have some effect in sensitizing the public to the need for reporting suspected cases. But the magnitude of this effect is unknown.

Even though hard supporting data do not exist, it seems apparent that the public information campaign, together with press coverage, spurred most of the reports by the general public.

From October 1, 1973 through September 26, 1974, the date of the most recent compilation of reports, reporting has dropped off slightly—from a daily average of 81.3 reports during Reporting Period 2, to an average 73.4 per day during Reporting Period 3. Nevertheless, the number of WATS-line reports has remained

Table 3

Reports by Source

Reporting Source	Reporting Period****					Cumulative (as of 9/26/74)	Change between Reporting Periods 1 & 2 (Percent)
		1		2	3		
	Oct.-March	April-Sept.	Year's Total				
PUBLIC	1,496	8,596	10,092	20,033	18,435	48,560	99
Neighbors	326	2,308	2,634	7,299	7,345	17,278	177
Relatives	374	1,845	2,219	4,342	3,751	10,312	96
Parents*	315	1,679	1,994	2,760	2,265	7,019	38
Anonymous	141	1,167	1,308	2,895	3,096	7,299	121
Other	340	1,597	1,937	2,737	1,978	6,652	41
PROFESSIONALS	2,719	6,917	9,036	9,653	8,065	26,754	7
Doctors	57	318	375	414	323	1,112	10
Nurses	102	332	434	486	441	1,361	12
Hospitals	56	163	219	386	457	1,062	76
Police	376	1,746	2,122	2,654	2,389	7,165	25
Attorneys	1	30	31	113	96	240	265
Courts	147	327	474	222	101	797	−53
D.Y.S.**	183	763	946	989	790	2,725	5
Schools	485	1,087	1,572	1,924	1,651	5,147	22
Social Workers***	661	1,949	2,610	1,804	1,348	5,762	−46
Clergy	16	48	64	99	75	238	55
Day Care Centers	14	91	105	121	171	397	15
Children's Residential Institutions	21	63	84	441	223	748	425

*Usually one parent reporting the other.
**Division of Youth Services, DHRS, which provides intake services in juvenile courts.
***Includes all social workers in all state agencies.
****Reporting periods are: Period 1—October 1971 through September 1972
Period 2—October 1972 through September 1973
Period 3—October 1973 through September 1974

constant, with 42.5 reports now called in each day compared to 42.1 per day during the second reporting period. A decline in reporting following a brief campaign is predictable, but reports from the general public seem to be holding up particularly well.

Increased Caseload. "Whatever the direct contribution of the campaign to increasing the caseload," said Geraldine Fell, "what we now have is a program that has outgrown its staff."

Between October 1971, when the hotline was opened, and July 1972, the DFS added 90 workers to the protective service staff. The Division had hoped to add 200 caseworkers the following year but, because of a cut in state appropriations, lost 58 instead. The net result was an increase of about 11.5 percent in staff to handle an increase of about 55 percent in reporting. The protective service program now has a staff of 249 caseworkers, 51 unit supervisors, and 11 regional casework supervisors. This staff of 311 people handles protective services for the entire state of Florida, which has a population of approximately 2,116,000 children under the age of 17.

In some areas of the state, the problems of understaffing have become acute. In Dade County, for example, there was a fourfold increase in reported cases between September 1973 and September 1974; during this same period, the county's protective service staff was reduced 10 percent. A recent informal survey of three Florida counties showed a rapidly increasing "pending" caseload—reported cases not yet investigated, with some reports more than 60 days old.

The shortage of CPS personnel is a statewide problem caused by lack of funding. Before the state's reporting law was revised in 1971, both the legislature and the governor expected that federal Social Security Act funds would reimburse Florida for 75 percent of the cost of the proposed protective service program. However, in 1972 Congress placed a nationwide ceiling of $2.5 billion on social service funding to the states. Florida, like most states, was caught short of money. The problem of understaffing is now so pronounced that further public education efforts have been terminated.

CPS staff shortages have impacted the provision of services

to identified families as well as the investigation of reports. When a report of child abuse or neglect is found to be valid, the DFS staff must be ready to take prompt action to protect the child and help the family. Despite the dramatic increase in reporting, the confirmation rate on reported cases has dropped only slightly since the campaign began. For the first reporting period, the confirmation rate was 63 percent; for the next year-long period, 60 percent; and is currently about 56 percent.

For confirmed cases, the protective service program is to provide a combination of counseling, referrals, and services such as emergency shelter care and foster care. If investigation of a case indicates the need, a caseworker may temporarily remove the child from the home. Within 48 hours, if the child cannot be returned home, the Division must petition the juvenile court for temporary custody. The child will then remain in shelter care, be placed with relatives, or in some cases will eventually be placed in a foster home. Caseworkers may also arrange for homemaker services for the family or may provide referrals to day care centers or mental health clinics.

Counseling is the caseworker's primary function. Whether or not the child is removed from the home, the DFS staff works with the family to alleviate the tensions that provoked the abuse or neglect. Many families require long-term counseling, which can last for months or even years. But with increasing caseloads and the reduction in staff, caseworkers are often unable to provide the in-depth counseling needed.

Scarce and inadequate treatment resources further hamper the Division's efforts to help identified families. Although many cases should be referred to mental health clinics, very little out-patient treatment is available in Florida. The few existing facilities are often ill-equipped to deal with either the children or the parents. According to Fell, "These are often isolated people who need to be reached in ways that are beyond the present capabilities of mental health units."

As Florida's experience shows, reporting alone is no remedy for abuse and neglect. An increase in the volume of reports, without a commensurate increase in the capacity to deal with identified cases, has limited value.

The revision of the Child Abuse Act, the establishment of the reporting and investigative system, and the sponsoring of the public information campaign are, to date, the primary examples of Florida's effort to coordinate an effective statewide protective program. Mary Ann Price of the protective service program feels that, as a result of these first steps, children are now better protected. "But," she adds, "hopefully, we will continue to improve on our services."

Guidelines for a Public Information Campaign

The Florida public information campaign has attracted interest in a number of other states. DFS has received many requests for information, and the advertising agency that produced the campaign has been approached by 15 other states interested in a public information program.

Those planning to conduct a campaign to inform the public about child abuse and neglect may find the following guidelines useful. They are based on suggestions from those who planned and produced the Florida program and, in part, on the guidelines proposed in an article by Duane Franceschi.[4] These guidelines should not be taken as hard-and-fast rules. Rather, they are presented as suggestions that may help others benefit from Florida's experience.

The first and most important step in planning any public information effort is to *determine the campaign's focus.* Geraldine Fell, one of three DFS officials who helped plan Florida's campaign, defines this step as determining how to present "the philosophical base you're working from, to the audience you're trying to reach."

It may be helpful to begin by posing and answering some basic questions. For example: Who is the intended audience? Is the campaign to be directed only to the general public, or to professionals as well? Will the campaign also attempt to reach parents who have the problem of abuse and neglect or who fear the potential in themselves? What is known about the local incidence of child abuse and neglect? How much does the public already know about abuse and neglect, the local reporting procedure, and local protective services? What are

people's attitudes about child abuse and neglect, about reporting, about intervention and treatment? As discussed in Chapter 2, data from the central register could be invaluable in helping to focus the campaign.

The most effective way to determine the public's knowledge and attitudes on the problem and management of child maltreatment is to *conduct a statewide survey.* The necessary time and money will be far better invested in such a survey than in a misdirected campaign.

Cost will vary according to the size of the state and the scope and depth of the survey. A Chicago market research firm estimated that a statewide survey could be developed and administered for approximately $7,500 at 1974 rates. If the budget for the campaign is limited, perhaps a local firm will donate its services or agree to a reduced fee.

One approach to such a survey would require a sample of 300 to 400 respondents, each interviewed for 15 to 20 minutes by phone. The questionnaire might be based on the one used in Dr. David Gil's nationwide survey, designed by Brandeis University and administered by the University of Chicago's National Opinion Research Center during October 1965.[5] A post-campaign poll, similar to that used before the campaign, should also be considered in order to evaluate the campaign's success and to determine whether continued or alternate public information methods are needed.

Formulate specific, measurable goals for the campaign. One goal might be an increase in public knowledge or a change in public opinion, measurable by "before and after" surveys. Another, as in Florida, might be "to make the reporting line ring." A major goal could be to build public support for more and better protective service units and treatment programs. Other possible goals include raising the percentage of validated reports; reaching specific foreign-language or cultural groups to assure that all state residents are informed; increasing the number of parents who ask for and receive help; or stimulating formation of local self-help groups. Goals should be determined by specific conditions within the state and the most urgent statewide needs.

Whatever the goals, *provide a means to evaluate the campaign's success.* Only through objective measurement and evaluation can you decide whether the campaign has been effective, whether it was worth its cost, whether it should be repeated, and whether in repetition it should be changed. Objective measurement will permit you to report the results of the campaign to the funding source and will be invaluable if you intend to ask for additional funding. Negative results will guide you in making positive changes; positive results—now or later—will increase public and government confidence in your operation.

The means for measuring results may have to be incorporated in the operations of state agencies. In Florida, for example, the impact of the campaign would now be known more precisely if the WATS-line procedure had included a question to callers on why they were reporting or how they had learned of the WATS number. Other possible goals, such as increasing the validity rate or increasing the requests for help from parents, can be measured through agency records if these data are recorded.

Thoroughly evaluate the material to be presented for its impact on the target audience and for possible unintended implications. Several DFS officials have indicated that if they were to conduct the campaign again, they would make at least two changes. One would be eliminating the copy line "These people are sick," referring to those who abuse or neglect children. Instead of castigating the parents, they would make a greater effort to inform them that help is available. The other major change would be to play down protection of the reporter from involvement. The campaign told the public that "you don't have to get any more involved than making a phone call"; but Florida's experience has been that, if the case goes to court, the reporter may be unable to avoid some degree of involvement.

Another recommendation is to *coordinate the information campaign statewide.* This would be difficult or impossible in a state with a city- or county-based system for reporting and investigation. One DFS official suggests that such states consider the advantages of statewide coordination, since both reporting and intervention can be more effective at the state level. A statewide system can use one telephone number for the entire state, bring

all reports directly into one central register, and handle all investigations through one state agency.

In planning and producing the campaign, *be professional.* Florida's experience shows the value of professionalism in gaining maximum exposure for campaign materials. The media are far more likely to use top-quality material than amateurish productions, no matter how worthy the cause.

To develop and produce a campaign as extensive as that in Florida, hire a professional advertising agency or public relations firm. If a full professional fee is beyond reach, a local agency may be willing to develop the basic concept and assist with production and distribution at a reduced fee. People from the agency could then suggest where professional help could be obtained for producing the actual materials. For instance, a local television station might agree to produce television spots, and a radio station might record radio announcements.

Plan the campaign in close cooperation with the communications specialists who will develop and produce the materials. Your continuing direction will keep their efforts in line with your goals. In turn, they can advise on the strategies most likely to be successful and on the results to expect.

If you cannot obtain professional help, contact local media representatives to find out if they will be willing to use campaign materials and, if so, the format that is most acceptable. Franceschi, for example, before beginning production, consulted with the Florida Association of Broadcasters, the Florida Press Association, and six outdoor advertising companies.

Once the campaign materials are produced, *plan distribution to ensure that the materials are used.* For maximum publicity, announce the campaign with a press conference conducted by the governor or some other state official. A press conference will be more effective than a brochure to inform the media of the campaign and to gain their interest and cooperation. To further assure media cooperation, use personal contacts rather than the mail to distribute the materials.

If possible, *arrange for personal follow-up contacts with each*

outlet—each radio or TV station, newspaper, and outdoor advertising company—to check if the materials have been received, to supply additional materials if needed, and to answer any questions. These contacts might be made 30 days after the materials are distributed, and again after 90 days. The follow-up could also be used to determine roughly the media exposure of the materials. Each outlet could be asked if the campaign materials are being used and, if so, how often. This information would provide a basis for evaluating the impact and the effectiveness of the campaign.

In addition to advertising media, consider using other means to publicize the campaign's message. For example, although advertising space in the Florida press was found to be a basically ineffective medium for the campaign's public-service ads, newspaper reports and editorials seem to have spurred public reporting in the state. Additional publicity might be generated by periodically informing the press and other news media of the results of the campaign.

Personal appearances are another valuable means of publicity. Representatives of the state's protective service agencies could appear on radio and television interview programs and "call-in" talk shows. Most voluntary groups such as PTA's and community associations are on the lookout for good speakers. A speakers bureau can be a welcome and effective way of reaching these groups and answering questions that cannot be addressed in detail by the materials produced for the advertising media. Personal appearances are also opportunities to distribute literature or to make audiovisual presentations.

The list of possible alternatives contains many other inexpensive and effective mechanisms for furthering public information. Whether these are intended to supplement the campaign or to stand alone, they should be planned and carried through with the same care and professionalism as the advertising media campaign.

A final guideline: *Keep the campaign itself in focus.* A campaign that attempts everything may be too diffuse to accomplish anything. Don't hope to alleviate abuse and neglect through information alone, and don't attempt a thorough program of

public education within the short-term format of an information campaign. Unless the specific goals of the campaign are kept in sight, resources of time and money may be spread too thin.

Not every community will be able to conduct a program as extensive as the Florida campaign. But public education can take various forms. Whatever form a community's education efforts take, think of the program as one link in a chain. Its purpose is to bring the other links together—specifically, to stimulate public awareness, action, and support. Each step in the campaign, each expenditure of time or money, should be directed toward eliciting a public response that is appropriate to local needs and compatible with the state's reporting, recording, and intervention facilities.

Information is a means, not an end. The real measure of its worth is what it contributes to the protection of children, to help for parents, and to the long-term goal of eliminating the conditions that lead to child abuse and neglect.

References

1. Elmer, "Hazards in Determining Child Abuse," p. 28.
2. Fontana, *Somewhere a Child Is Crying: Maltreatment—Causes and Prevention,* pp. 165–172.
3. Ibid., p. 165.
4. Franceschi, "Reflections on the Florida Child Abuse Public Information Media Campaign."
5. For more detailed information, see Gil and Noble, "Public Knowledge, Attitudes, and Opinions about Physical Child Abuse in the U.S."; and Gil, *Violence Against Children: Physical Child Abuse in the United States,* particularly Chapter 3.

Chapter 5
Coordination and Guidelines*

As illustrated in Chapter 1, the community-team program comprises three interlocking components—identification and diagnosis, treatment, and education. Among the three components, coordination is the central link.

To be effective, coordination has to function on two levels. At the program level, there must be coordination among all the people, resources, services, and procedures involved in the management of abuse and neglect in the community. At the case level, the delivery of services to each family in need must also be coordinated.

Program Coordination

In a well-coordinated program, gaps and duplication among services are minimal, and the role of each worker and agency is well defined. In such a program, cases of abuse and neglect can be handled in a systemic way, but with individualized management, planning, and treatment.

Program coordination can involve any number of administrative tasks, including identifying problems in the community; handling problems between agencies; overseeing the development of new services, such as a diagnostic consultation team or parent aides; obtaining funding for the program; maintaining liaison with the agencies involved; and recommending changes in services, policies, and procedures as needed.

In most community programs, coordination is either handled by a designated person or an inter-agency committee, or is shared between the two. For example, in Toledo, Ohio, coordi-

*Adapted from material written for the Office of Child Development in 1974 by Deborah Adamowicz, Brandegee Associates, Inc.

nation is handled by an advisory committee—consisting of administrative representatives of the agencies involved in the program—and by a full-time program coordinator, who is paid by a private agency but accountable to the committee.

If coordination is handled by one person, the coordinator should coordinate rather than direct the people and agencies involved in the program. If an interagency committee coordinates, it should ideally comprise both agency administrators and people from the community who have necessary administrative skills—a banker or a businessman, for example. Rebecca Schmidt, the coordinator of the Toledo program, feels that professionals involved in case management—social workers, doctors, nurses—should not be included on a coordinating committee: "That's like putting a faculty member on a university's board of trustees—there are too many conflicts of interest."

Case Coordination

At the case level, both short-term and long-term coordination are needed. Short-term coordination extends from the time a case is identified until a treatment plan is developed and implemented. This phase of coordination, handled by caseworkers from the protective service agency, involves seeing that the child is protected and the family assessed, and arranging for the treatment that is best suited to the family's needs.

Long-term coordination begins as the family is being readied for referral for treatment and extends until the case is closed, which may be months or years later. The function of long-term coordination is to prevent families from "falling through the cracks"—to ensure that treatment appointments are kept, that the treatment planned is followed through, and that additional or alternate services are provided if needed.

Various professionals hold that protective service caseworkers are and should be responsible for both short- and long-term case coordination. Since caseworkers have the mandated responsibility to protect children, they must be in charge of case management from the time a case is opened until treatment is completed.

Others, however, point out that there are risks in having one person handle both types of case coordination. In many communities, various factors—such as excessive caseloads or regulations that cases be closed within a certain time—prevent the caseworker from handling long-term coordination effectively. In addition, protective service caseworkers are specialized in crisis management. Once a family has been referred for treatment, it may be more efficient for long-term case coordination to be handled by someone who has the time and commitment to regularly follow up on the progress of each family, rather than to have the caseworker handle this fairly routine though essential job. If problems should occur during treatment, the case coordinator would, of course, refer the case back to the protective service worker. In this sense, the long-term case coordinator functions as both a support to protective services and a resource to ensure that each family receives the services that are needed.

Guidelines for Developing a Community-Team Program

Given the complexities of a good community program, the question is where and how to begin. Who initiates planning and action toward a community program, and how does one go about it?

The following guidelines are offered to those who want to initiate or improve a community-team program. This is not a set of how-to-do-it instructions. The guidelines are practical suggestions to facilitate the task of developing a working program in most communities. They are no one's exclusive ideas; rather, they reflect the thoughts and experiences of many professionals throughout the country.

The first suggestion is to *bear in mind that there are three components of a complete community program,* as discussed in Chapter 1. The full effectiveness of each component depends on the effectiveness of the others. Plan to move toward all at once, at approximately the same pace of development. If some of the elements are already present in the community, remember the probable need to modify or adapt them to the special problems of child abuse and neglect, and to coordinate them with new elements as they come into being.

A "prime mover" has to get things going. The first step in creating a community team is forming a small, interdisciplinary planning group. This initial group should be quite informal and, ideally, should comprise a member of each profession involved in case management. The prime mover who gets this group to begin meeting can be one individual or several. The person or people need not come from any particular background or profession. The prime mover is a facilitator, not an authority figure, and can be anyone with the will, the energy, and the patience to organize several initial small-group meetings. Some people feel the prime mover should come from a social service background; others recommend that it be someone from the medical profession; to still others, the prime mover should be in a position of neutrality among the professions. There is something to be said for all three points of view. But the most important thing is that *someone* devote the time and energy necessary to initiate a planning group.

Developing realistic understanding and trust among professionals is the first job of any group that gets together to plan community coordination. The planning group must be multidisciplinary if it is to be effective. Despite the traditional autonomy of the different professions, the members of the group must find ways to work together effectively. Probably their most important task in the beginning is simply to listen to one another. Since part of their mission is to teach families to break through their isolation and to begin to trust, they themselves must learn to be interdependent and trusting.

Don't expect instant results. Real understanding and trust between members of different professions, previously isolated and keenly aware of their own prerogatives, takes time. Coordination, in most communities, is not a simple matter of dividing up and delegating duties. According to Dr. Robert S. Stone, former director of the National Institutes of Health: "The development of a team, as distinguished from a collection of health care professionals who happen to work in the same building, is a question of interaction between people—of each influencing the others constructively, and of each permitting himself to be influenced by the others."[1] Real coordination on a complex and demanding job has to be worked out in practice, sometimes

painfully. Don't expect to develop a functioning team in months; think in terms of two to three years.

Getting acquainted and establishing a common ground for discussion should occupy at least the first few meetings. Don't try to solve problems in these early meetings; spend them getting to know each other's backgrounds, problems, points of view, and competences.

Define the goals of the group and the roles of the professions and agencies represented. The expressed goals will, of course, have a pronounced effect on what the group does. Some goals are nearly universal—for example, to facilitate early identification and appropriate intervention and treatment. Subsidiary goals vary, depending on the needs and existing resources of the community. For example, one group may focus on treatment for the parents, while another may concentrate on better medical-diagnostic facilities.

Again, bear in mind that the program's three basic components should be developed in unison. The program as a whole will be crippled if some components are missing or weak. For example, sophisticated reporting and diagnostic resources will have little if any value if treatment facilities are in short supply. Likewise, well-developed treatment programs will have less than optimal effect unless the public is informed of their existence and appropriate reporting and diagnostic resources are available.

The roles of the various professions in the community may seem self-evident to the planning group at first, even though there may be overlaps in what is actually done and gaps among the services offered. One way to begin clarifying roles is to ask each professional in the group to list, in turn, the things he or she does when handling a case. The point is not to discuss or justify, but simply to list. Then, as a group, list the procedures and services which ideally should be available, regardless of who provides them. A comparison of this ideal list against the lists of actual services each profession provides should point out gaps and duplications among services in the community.

Develop a definition of child abuse and neglect. While the state's legal definition controls the action of the court, a broader

typology of abuse and neglect is required for casework and preventive intervention. Definitions tend to vary according to the backgrounds and customs of the community; and the definition adopted will determine the kind of action taken, particularly in case identification, referrals among agencies, and the approach to treatment planning. Some state laws, for example, define certain types of maltreatment—such as overt physical injury, inflicted nonaccidentally—as abuse and as a criminal action. The obvious response is prosecution and punishment of the parents. A quite different definition—"a family crisis which threatens the physical or emotional survival of the child"[2]—focuses on resolving or preventing family crises.

The extremes of physical abuse and neglect are easy to define—fractures, burns, serious malnutrition, or death. Other forms of maltreatment which can be equally serious, such as psychological abuse or emotional neglect, are hard to define and identify and even harder to write into law. Nevertheless, their recognition in the community's definition can make a great difference in the scope of services provided. (See Volume 1, Chapter 1 for a more extended discussion of defining child maltreatment.)

Define the "community" that the program is to serve. Accepting a political entity—a city or a county—as the community does present the possibility of local government backing for the program. For maximum program effectiveness, however, the community should be defined primarily by the population served rather than by geographical or political boundaries. Helfer's concept of regionalization, discussed in Chapter 1, focuses on the effect of the size of the community's population on the program. A region should be big enough, he says, to provide the necessary services, but not so big as to be unwieldy. Coordination by regions—each comprising 200,000 to 500,000 people—would, in his opinion, allow for optimal service delivery. From this perspective, program development is generally impractical and often impossible when based on the county unit: only 127 of the nation's 3,000-odd counties have populations of 250,000 or more.

Identify the problems in the community. Pinpoint the most significant gaps in services and the greatest obstacles to the development of a quality program. A list of major problems

might include the punitive approach of the local police; the disastrous understaffing or absence of a child protective service unit; or the near-automatic removal of threatened children from their homes because of the lack of treatment programs for parents.

Get down to earth by consulting on actual cases early in the planning process. Different members could bring cases to the group for discussion. And even at this early stage, members can consult with one another on cases without any serious compromise of the autonomy of the professional primarily responsible. The families will probably benefit from the consultation, while the professionals will gain real-world insights into each other's problems, methods, and assumptions. Most important, by working together, the members will probably discover that they need each other—that none of them alone can adequately handle a case.

Inform the agencies represented by the members of the planning group of the purpose and progress of the meetings from the start. Their understanding will be needed later for support, in the form of money and personnel.

Identify "advocates" in the community who can help solve problems. Having established mutual confidence and a common point of view, the group can begin to involve others as needed. A juvenile court judge or a district attorney may help to modify punitive legal practices; a school teacher or principal may help with identification of abuse and neglect in the schools; an editor or advertising agency may help with public information work; a legislator or mayor may work toward improving laws concerning abuse and neglect; the administrative heads of agencies can help smooth out coordination of services.

Among the advocates should be representatives of citizens in the community. The program must reflect community as well as professional standards. No service can reach its greatest effectiveness without community support. Dr. Edmund Pellegrino has observed that "the health professional is always in danger of extending his authority in technical matters over the patient's system of beliefs and values."[3] Many ways to involve citizens in the planning process have been suggested, ranging from form-

ing a citizens council which would act as an advisory group, to membership of laypeople—including former abusive parents—on committees or planning and evaluation teams.

Delegate specific tasks to individuals or small groups. A successful program will require the input of various people. People will be needed to develop training programs and a public information program, to establish diagnostic teams, and to set up a therapeutic development group. Once the planning group has established trust and a shared view of the goals and purpose of the program, it can seek out groups and individuals to assume such responsibilities with little concern about possible bias or "slanting" of the results toward the interests of one profession or agency.

Approach the administrative heads of agencies for help. By this time—perhaps a year or more since the initial meeting—the planning group should be well informed about community problems and resources and accustomed to cooperating across discipline and agency lines. What the program needs now is some key full-time personnel, including a program coordinator and a case coordinator, and funds to get proposed programs under way. If administrators have been kept informed of the group's progress from the beginning and are convinced of the program's importance, they should be amenable to working together as a group—as an advisory committee or board of directors—to handle the specifics of obtaining and assigning funds and personnel.

It should be noted that funding is not necessary early in the development of the program—it may, in fact, create obstacles. When money for program development is sought before planning is well under way, unnecessary conflicts can arise on how to allocate and spend it. Fund raising should probably not be tackled until at least the second year of program development. By then, plans for the program should be fairly sound, and agency administrators should be meeting as an advisory group or board that can coordinate funding needs.

A final guideline is to *plan and implement programs of primary prevention.* With the aid of community support, personnel and funding, careful planning for the needs of the community, and

trust and understanding between professions and agencies—all of which should now be on a sound basis—the various components of the community program should be functioning as a well-ordered system. At this time, expansion of the program to include mechanisms of primary prevention should be considered (see Chapter 6). If the community attempts to initiate a full-scale prevention program before diagnostic, treatment, and education programs are established, the program will most likely "fall flat." On the other hand, a community with a well-functioning program that ignores primary prevention is side-stepping the issue that is the logical next step in the management of child maltreatment.

These guidelines are not intended to make the process of program development sound easy. On the contrary, expect it to be long and difficult. There will likely be problems with people and resources in the community; and there may be problems whose sources are outside the community and difficult to influence—state laws, for example, or funding sources with conflicting ideas about the use of funds. These guidelines are not offered as a solution to all problems, but as a logical approach which may help to multiply the effectiveness of people—professional and lay alike—in serving the needs of the community and its families.

References

1. Stone, "Education for Life-Styles: A Role for the Health Care Team."
2. Newberger, Haas, and Mulford, "Child Abuse in Massachusetts," p. 32.
3. Pellegrino, "Educating the Humanist Physician: An Ancient Ideal Reconsidered," p. 1290.

Chapter 6
Primary Prevention*

Somewhere between the goals of practical men and those of visionaries lies the area of primary prevention. A community with a well-coordinated program of identification, treatment, and education directed toward the problem of child maltreatment has already initiated preventive measures, although these can prevent abuse and neglect in only a secondary way—by limiting its extent and recurrence. Primary prevention focuses on preventing the first occurrence of child abuse or neglect in a family.

Some professionals doubt that complete prevention of child maltreatment is even possible. It would require, they say, a total change in our social fabric, the creation of Utopia. Others consider primary prevention a more or less reachable goal. They propose that, while the abuse and neglect of children may never be completely eliminated, there are definite steps a well-coordinated community can take in the direction of this objective.

This chapter examines, in the context of the community-team program, various preventive steps that have been proposed. None of these measures is new or unique. Many have been suggested elsewhere, often for specific purposes other than the prevention of child maltreatment. But for at least three reasons, there have been few attempts to implement most of the measures discussed in this chapter. First, preventive action requires a well-coordinated community effort, and community coordination is still relatively rare. It also requires an effective service-delivery system, quite the opposite of our typical community services, which can seldom meet even chronic or emergency family needs. The third and probably most basic reason for the current scarcity of preventive action is that primary prevention of child abuse and neglect will require a change in attitudes and priorities—in communities and institutions, and in people as well.

*Adapted from material written for the Office of Child Development in 1974 by Deborah Adamowicz, Brandegee Associates, Inc.

For these reasons, a community-team program may be the most effective base for developing and implementing a local program of primary prevention. In a community with a well-functioning abuse and neglect program, the various professionals and agencies involved in case management have already coordinated their efforts and should be working together with relative smoothness. In turn, the delivery of services to families should be functioning effectively; there should be few, if any, gaps in needed services and little duplication of effort. The public should already be aware of the problem of maltreatment and of the services available to families locally. In such a community where mechanisms for identification, treatment, and education are coordinated and functioning, the ground has already been laid to incorporate preventive aspects into each of these three program components.

This chapter contains no guidelines for preventing child maltreatment, but two points deserve comment. One is that primary prevention should be planned with the same care given to any other aspect of the community-team program. Second, preventive mechanisms, like all other services and resources, have to be selected and developed according to the needs of the community. It is quite possible that few or perhaps none of the points discussed below will be used by a particular community. But if these ideas stimulate thinking as to what form local preventive action can and should take, this discussion will have fulfilled its purpose.

Identification

The identification of families having the problem of abuse or neglect generally occurs through identification of the child or children. The injury or condition of the child is what usually leads people to suspect and report maltreatment. But in the preventive sense, identification focuses mainly on parents with the potential to abuse or neglect their children.

Like reporting, preventive identification should not be an accusatory action, but a means of reaching out to families in need of help. To ensure that reach-out mechanisms do not become devices for meddling, surveillance, or unwarranted intervention, it is important that the identification component be

carefully planned and coordinated. Questions such as the following should be considered: Who is to be identified? That is, what are the characteristics and factors that suggest a family is at risk for abuse or neglect? How are families to be identified —through a report to the child protective agency or to a multidisciplinary team, or perhaps through interagency referrals? Is formal identification even necessary? What happens once a family is identified? How will they be helped? What happens if a family refuses help?

There are various possible approaches for identifying families with a potential for child maltreatment: for example, through general identification resources, through the use of predictive models, and through the identification of "special" children.

Identification Resources. Any professional who has contact with parents in the pre-, neo-, or postnatal stage is a potential identification resource—obstetricians, public health nurses, pediatricians, public welfare workers, the staffs of prenatal and well-baby clinics, day care workers, and teachers, to note a few. The actual effectiveness of any professional in this capacity is determined by his or her sensitivity toward parents' problems, and knowledge of factors that can influence abuse and neglect.

For instance, during regular office visits, the pediatrician could make a point of asking each mother and father how they are getting along: Are they having any particular problems with their children? How do they feel about their children? When there are problems in the family, do the parents have someone to turn to for support? Do the parents help and support one another, or does one carry the burden of child care alone? Such gently probing questioning can serve a dual purpose: it shows concern for the parents, and it helps the professional detect problems that the parents might not otherwise mention. With knowledge of the family's problems and needs, the professional can then refer the parents to appropriate community services.

Any well-publicized therapeutic service equipped to handle self-referrals can also function as an identification resource. Examples include crisis-intervention hotlines, Parents Anonymous, therapy groups, homemaker services, therapeutic day care centers—in fact, practically any of the treatment modalities dis-

cussed in Chapter 3. If parents are aware that such services are available to any family in need of support, they may refer themselves before their problems reach a crisis stage. Having approached one group or agency, the parents could then be directed to additional or alternate services if necessary.

Predictive Models. The development of screening programs to identify families in which child maltreatment is likely, even though it has not yet occurred, raises both practical and ethical questions. Dr. C. Henry Kempe, for example, notes that on the basis of data now available, there is no certainty that an adequate screening tool can be developed. According to Dr. Vincent De Francis, the likelihood of coming up with a truly predictive scale is not very high. Dr. Ray Helfer, on the other hand, speculates that effective early-identification instruments will be validated and used within the next decade.

While various screening tools are currently being developed,[1] ethical questions remain. The problem is not with screening and identification per se, but with the method and quality of intervention once a person or family has been identified as having the potential for abuse or neglect. Professionals agree that the most acceptable form of intervention would be the provision of needed educational, therapeutic, and social services to families willing to receive them. But what if the family refuses? Does protective services or any other agency have the authority to intervene before a child is born or before there is evidence that a child may be at risk? The answers to these questions will undoubtedly influence our ability to prevent the occurrence of abuse and neglect.

The "Special" Child. As discussed in Volume 1, Chapter 2, children who are abused and neglected tend to be misperceived by their parents as "bad," "stupid," "mean," or in some way different from other children. Dr. John Caffey has pointed out that deformed, premature, multiple-birth, adopted, foster, and stepchildren—those who are, in reality, different—run a higher risk of maltreatment than "normal" children do.[2]

A program of primary prevention could include early identification and follow-up of high-risk "special" children and the provision of educational and social services to their families. For

example, the parents of a physically or mentally handicapped child could be provided appropriate diagnostic, treatment, and educational services. In such families, regular visits by a public health nurse or a homemaker-home health aide could provide valuable parental support.

Treatment

Once a community-team program begins to incorporate preventive measures, the program's treatment component may assume a far broader role than before. The focus of treatment has to be expanded to include families identified as having a potential for abuse and neglect. Depending on the specific needs of the parents and children, the family may require any of the therapeutic resources mentioned in Chapter 3.

In a broader sense, treatment can be focused on the community itself—on the external factors that may influence a parent's potential for abuse and neglect. The preventive mechanisms discussed below involve hospitals, schools, businesses, neighborhoods, and the community as a whole. The discussion includes three basic categories of preventive action: modifications in the health-care system, measures to support family life, and ways to help people manage personal crises more effectively.

Before discussion of these areas, it is important to look at how preventive measures can be developed and implemented. One way is for the community program's therapeutic development group, discussed in Chapter 3, to expand its scope to include prevention. In much the same way that the group approached therapeutic development, it could encourage groups, agencies, and institutions to modify their practices and offer prevention-oriented programs.

As another alternative, preventive action could be planned and implemented by a group devoted to increasing community support for families. For example, Forum 15 of the 1970 White House Conference on Children recommended that each community form a Council for Families and Children as a means to make the community a more favorable environment for family life.[3] Such a council would include representatives of child- and family-oriented institutions and agencies, businesspeople, parents,

teenagers, and preteen children. The concerns of the council would extend beyond child maltreatment alone, but it could be affiliated with the community's abuse and neglect program, and many of its activities could amount to preventive treatment for the community.

Modifications in the Health-Care System. Various studies indicate that a significant number of abused and neglected children were low-birth-weight (premature) infants.[4] As a group, their maltreatment may indirectly result from the traditional hospital practice of isolating low-birth-weight babies from their parents, often for long periods of time. Elizabeth Elmer of the Pittsburgh Child Guidance Center notes that "very early separation can be damaging to the mother" and that studies point to this as one of the prime factors in later maltreatment.

While hospitalization of premature infants is necessary, isolating them may thwart the parents' development of positive feeling for the child. When mothers of premature babies are allowed very early contact with their children and are allowed to participate in their care, twofold benefits can result: the infants tend to progress more rapidly, and their mothers relate to them more easily.[5] As Dr. Ray Helfer notes: "The results show up maybe two years later. Mothers having early contact with their newborns develop a different way of talking to, relating to their kids than those who are denied this contact." The effects of early isolation on the mother-child bond suggest the need for changes in our system of protecting all newborns from infection.

Many hospitals now provide prenatal classes for expectant parents. With several modifications, these classes might prove effective in preventing the maltreatment of children who are not yet born. Prenatal classes could be extended to include both mothers and fathers, from early in pregnancy to at least several months after the baby's birth. Ideally, they would be available in any hospital or clinic providing prenatal or obstetrical care. Gynecologists and obstetricians, informed of the existence and importance of these classes, could urge couples to enroll as soon as pregnancy is determined. In class, couples could be instructed in prenatal and newborn care; perhaps more important, they could be emotionally prepared for the role and responsibility of being parents.

The continuation of classes beyond the child's birth is important for several reasons. Most new parents require more information and support after than they do before the baby is born. Postpartum depression, a colicky baby, and other factors that the parents may have calmly anticipated before delivery can take on unexpected proportions once they are alone with the child. In class each week, along with their own and other newborns, many parents will be able to see that their child and their problems are not unique; and, as in many group programs, they may provide one another with mutual understanding and support. Either formal or informal predictive screening programs could be used in these classes as a way to detect and treat various family problems early.

The classes for parents could be affiliated with an infant and child health program in the same hospital or clinic. During regular pediatric visits, the parents are likely to feel more comfortable in asking questions and discussing problems if they are already familiar with the facility and the staff. In turn, the staff's knowledge of the parents' problems and needs, obtained through their participation in the classes, should result in more individualized care.

The development of such comprehensive pre- and postnatal programs and their accessibility to all expectant parents—in terms of both location and cost—should have a definite impact on reducing infant mortality as well as on preventing abuse and neglect. In some cases, mortality during the first year of life may be related to inadequate prenatal care. In the mid-1960s, federally funded projects for maternal and infant care were developed in poverty areas in 14 cities.[6] Within four to five years, infant mortality rates in these areas dropped sharply—in one case, by more than half. Among those served by these projects, the number of premature births and unwanted pregnancies also declined.

Still another preventive measure is the use of the health visitor, a practice common in several countries. In Scotland, for example, it is required that all preschool children be seen periodically in their homes by a health visitor.[7] Should there be a developmental problem with a child, the visitor either works with the parents or refers them to appropriate services. A health visitor program could be invaluable in the identification and treatment of condi-

tions that could lead to abuse or neglect, and could offer a means for personal contact and periodic health checks to even the most isolated families.

Support to Family Life. According to Dr. Morris Paulson, principal investigator of UCLA's Child Trauma Intervention and Research Project, "people are beginning to look beyond the concept of child abuse, to see it as just one example of the breakdown in family life."

There are various data pointing to the fact that the American family is indeed breaking down.[8] In Massachusetts, 50 years ago, at least one adult in addition to the parents was included in half of all families; today, only one family in 25 includes an additional adult. Nationwide, the percentage of children whose parents are divorced has almost doubled in the past 10 years. Between 1965 and 1970, day care enrollments increased by 50 percent; nevertheless, the number of children who return from school to an empty home is said to also be on the rise.

Other research findings suggest that even intact families are losing much of their traditional cohesiveness. For example, a recent cross-cultural study of the uses of time indicates that, compared to their European counterparts, American parents who are employed and married spend the highest ratio of free time alone rather than with family members.[9] Even when parents and children spend time together, meaningful contact between them may be minimal. For instance, a sample of middle-class fathers claimed to average 15 to 20 minutes a day playing with their year-old infants; yet one study found that the mean number of daily interactions between fathers and infants was 2.7, and that the average time spent interacting was 37.7 seconds a day.[10]

Dr. Urie Bronfenbrenner, professor of human development and family studies and of psychology at Cornell University, names various factors that serve to isolate parents and children from relatives, neighbors, and other traditional support systems—and from one another as well. Included are the decline of the extended family, the functional breakdown of the neighborhood, occupational mobility, the demands of a "rat-race" culture, and the increasing professionalization of child care.[11] These are also among the influences Bronfenbrenner refers to when he calls

child maltreatment a product of "the circumstances in which people are forced to live." From his perspective, prevention requires the reinvolvement of adults and children in each other's lives: "Any device which furthers such involvement could function to reduce child abuse by providing essential emotional support to those who care for children."

To facilitate prevention planning, Bronfenbrenner suggests that an initial audit be conducted to determine what the community is doing and what it is not doing to support family life. Any number of specific questions could be raised: Where are the children and who takes care of them? How many children are left unattended because their parents are working or otherwise occupied? Does the community have enough adequate maternal and child health services, day care facilities, recreational facilities? What opportunities are there for real interaction among various age groups? The questions asked and the answers obtained would determine where and how preventive action is directed.

Neighborhoods. In many communities, the functional neighborhood is a thing of the past. Interaction between neighbors tends to be limited to a passing nod, and often neither knows the other by name. In such neighborhoods, family isolation is common, and children are more likely to be abused and neglected.

The redevelopment of functional neighborhoods could prove to be a key element in the prevention of child maltreatment. One possible approach is through the use of "block parents."[12] Local schools could be asked to identify one or two parents in each block who are well known among their neighbors. These people would then be asked to assume the role of block parents. They would get to know their neighbors, identify the problems in their blocks, and organize neighborhood-based activities. In short, their task would be to initiate the concept of neighborliness—people knowing and helping one another.

Other devices for revitalizing neighborhoods include neighborhood family centers where "leisure and learning and community problem-solving" programs could be provided for people of all ages, and where legal aid, child care, health, welfare, and other family-oriented services could be obtained;[13] recreational and

day care facilities located in areas easily accessible to families; and public places throughout the community where children and adults can walk and talk and sit together.[14]

Business. Any community attempting to prevent the maltreatment of its children, and concerned about upgrading the quality of family life, should include business and industry as potentially strong allies. The report of Forum 15 of the 1970 White House Conference on Children explains: "To an extent not generally recognized, the patterns of life of American families are influenced by employment policies and practices. Employers, both public and private, can make a significant contribution to placing families and children at the center rather than on the periphery of our national life." [15]

Specifically, as the conference report indicates, employers could be made aware of the need for minimizing out-of-town, weekend, and overtime obligations; reducing geographic moves; increasing the number and status of part-time jobs; making work schedules as flexible as possible; giving leave and rest privileges to pregnant women and new mothers and fathers; and locating day care facilities at or near the parents' place of employment.[16] Such actions could benefit employers as well as workers: the potential economic advantages include more and better production, and lower turnover and absenteeism.[17]

Employers may also be amenable to more innovative approaches to fostering adult-child interaction and understanding. Children are generally excluded from the world of work and responsibility. Rarely are they able to observe their parents, or any adult other than teachers or pediatricians, at work. To counteract work-related segregation of children from adults, Forum 15 recommended a practice common in the USSR: that business firms or departments "adopt" a group of children—a school classroom, a nursery school class, a Boy or Girl Scout troop.[18] The workers could periodically visit the children's group and, on occasion, could invite the children to their place of work. The objective is not vocational education, but to acquaint children with working adults, and workers with children and their families.

An example of such a program is depicted in the film, *A Place to Meet, A Way to Understand*, produced by Forum 15. The pro-

gram it documents was arranged on an experimental basis between the Detroit *Free Press* and the sixth-grade classrooms of two public schools—one in a slum area, the other in a middle-class neighborhood.

Schools. As it operates today, our educational system may be failing both children and families in various ways. Urie Bronfenbrenner observes that children are drilled in subject matter, while the "development of a child's qualities as a person—his values, motives, and patterns of social response"—is virtually ignored; schools purport to prepare children for "life," yet rarely equip them with either education for parenthood or training for responsibility, decision making, and problem solving.[9] Just as business and industry separate children from adults, our educational system isolates them—and their teachers—from both adults and children of other ages. Although schools could have a major impact in reducing the potential of future parents to maltreat their children, at present they do little to suppor family life.

There are a number of things that schools could do as part of a community's program of primary prevention. Probably most important, school systems could institute a mandatory human development curriculum, including education for parenthood* and family life for students from kindergarten through high school. The curriculum could incorporate various studies: from hygiene and family planning to human interaction and how communities function. While the specifics of the curriculum would vary with the community, the general objective would be to better prepare children to become responsible adults—including, of course, preparation for parenthood.

Vincent De Francis suggests that, for very young children, such education could take a subliminal form. Readers, for example, could contain stories about Mama and Papa Bear, their inter-

*Under a grant to the Education Development Center, Cambridge, Massachusetts, the Office of Child Development, in cooperation with the Office of Education, has developed a curriculum in education for parenthood for use in grades seven through twelve. The curriculum is being used in a number of schools across the country. In addition, seven youth-serving organizations have received OCD grants to design their own parent-education curricula for use outside the schools (for example, the Boy and Girl Scouts and 4-H Club members). For further information, write to the Office of Child Development.

actions with their little bears, their realistic handling of crises, and their next-door neighbors who love children dearly but have decided against having any of their own. As children progress, the curriculum could become more formal. They could learn not only about the practical aspects of parenthood—how to feed and diaper a baby, basic child development, what to expect of a child at a particular stage—but about the emotional aspects as well.

For example, the curriculum could include among its goals a change in the current permissive attitude toward physical discipline of children. In school, children could be taught that anger and frustration play an unavoidable part in parenthood, but that there are ways to cope with negative feelings; that through even mild corporal punishment, the young child can be injured; and that there are more constructive forms of discipline than spanking and physical force. But children learn through example as well as through instruction. The child who is physically disciplined in school learns that the use of force against children is considered acceptable, and may later apply the lesson to his or her own children. Elimination of corporal punishment in schools, and substitution of other forms of motivation, would demonstrate the community's concern for nonviolent discipline and provide examples of methods.

Children could also learn that, in bearing and raising a child, one assumes a highly responsible role—a role that not everyone should undertake. Accordingly, sex education and birth-control information should be included in the curriculum. With the increasing rate of births among girls aged 10 to 14,* it is obvious that such information should be provided in junior high school, if not earlier.

The location of day care centers, crisis nurseries, and other preschool programs in or near secondary schools could serve a threefold purpose. Older students could gain both practical experience and course credit by working, on a regular basis, with the younger children. They could be entrusted with actual respon-

*According to the 1974 *Statistical Abstracts*, the rate of live births among this age group rose from .8 births per 1,000 population in 1960 to 1.2 per 1,000 in 1970, the latest year for which data are available. In actual figures, there were 6,657 live births among girls aged 10 to 14 in 1960, compared to 12,246 in 1970.

sibilities—as opposed to customary "duties"—requiring judgment and decision making, such as involvement in planning and operating the programs. In addition, such programs would begin to replace the traditional age-related segregation in our schools with interaction between young children, adolescents, and parents and other adults.

Schools could also develop and publicize classes for adults in parenting education and family life. Classes available both in the daytime and the evening would allow for more flexible enrollment and for a mixture of adults and teenagers in the classroom. While the classes would be directed toward strengthening "normal" families, they could also serve as a therapeutic resource and as a means to identify parents with a potential for abuse or neglect.

Crisis Management. Crisis occur in every family. In the abusive or neglectful family, they are often a way of life. The parents are characteristically unable to plan ahead, to anticipate crises and head them off and to attack problems analytically. They are also unlikely to deal with problems at all until they have reached the crisis stage.

These typically isolated families get little or no outside support with their problems. Since the parents often have a tragically low opinion of themselves, they are vulnerable to anything that may diminish their self-esteem. To them, an incident that other families might regard as minor—a child breaking a lamp or a marital argument—may be the overwhelming "last straw" of a perpetual series of crises, and may trigger abuse.

It is impossible to prevent all crises. What can be attempted at the community level, for the short term at least, is the provision of services and facilities to help families cope with crisis and to help relieve stress. For example, a 24-hour crisis-intervention hotline, as discussed in Chapter 2, could give a distraught parent somewhere to turn. Understanding and support over the telephone can help in many cases; but callers could also be directed to other services for additional ongoing help.

Crisis nurseries or a free crisis-babysitting service, available 24 hours a day, could help relieve some of the stress of a mother

in a time of crisis, and would protect her children until the danger is past. Family crisis centers, an extension of the concept of the crisis nursery, could provide a temporary refuge for the whole family—safety for the children and support and counseling for the parents.

Day care ideally offers not only social stimulation to the children of isolated families, but a way to relieve parents of the seemingly endless burden of child care. As Bronfenbrenner explains: "Taking care of kids can be very, very hard work. When you have to do it essentially 24 hours a day, and are under the demands of a very young child, and there's nobody else to spell you off . . . then you can go batty. That's when child abuse comes in." For day care to play a preventive role, the cost and location of facilities would have to be within the reach of all families.

Poverty is almost universally recognized as an aggravating influence to families at or near the point of crisis. Dr. David Gil points out that "environmental stress and strain are considerably more serious for persons living in poverty than for those enjoying affluence" and that "the poor have fewer opportunities than the nonpoor for escaping occasionally from child-rearing responsibilities." [20]

There may be limits to what one community can do about poverty, but much can be done to relieve its impact. For example, depending on its size, a community can provide a certain number of additional jobs for those who are unemployed. It can arrange for crisis-oriented financial support, provided without long waiting or excessive investigation. Crisis housing can be prearranged, ready for emergency use. In addtion, a community can work with and support local social service agencies to make the delivery of services to the poor less chaotic, more reliable, and more supportive to the personal dignity and self-esteem of the recipient.

For the longer range, communities can help prepare their members to deal with crises more effectively. Local school systems can be induced to put far more emphasis on learning about values, learning to make decisions, and developing the ability and the habit of accepting responsibility. Children, from the earliest elementary grades, could be given actual responsibilities

in both the school and the community. They could be taught problem-solving skills and crisis-management techniques. They could also be involved, far more than at present, in group activities—with peers as well as children and adults of all ages—so that they can learn constructive interdependence.

Education and Training

With the addition of a preventive focus, the community program's education and training component would not be essentially changed. The function of those comprising this component would be much the same as before: to educate the community, to train professionals involved in cases, and to conduct public relations work. The main difference would be in the expanded focus of education and training.

For example, the goals of public and professional education could be broadened to include increasing people's awareness of primary prevention. The public should know what steps the community is taking to prevent abuse and neglect, and how individual citizens can become involved. All parents should be aware of the services available to any family in need of support. Professionals who work with parents and children should be aware of the characteristics of high-risk families, the services available to these families, and how to refer a particular family for help.

Education could be directed toward specific groups to inform them of their potentially valuable role in eliminating child maltreatment. One project could be to convince school boards, the state board of education, and individual teachers of the need for changes in the educational system. Another could be to help employers recognize and modify their impact on family life. A program of primary prevention will require the involvement of the community as a whole. Appropriate education and training are essential to producing a climate in the community for preventive action to succeed.

* * *

The proposals in this chapter do not constitute a design for Utopia. They are not guaranteed to prevent family crises nor to eliminate the abuse and neglect of children. But, together, they

could help make any community a better and safer place for children and families to live.

Blaise Pascal, the seventeenth century French philosopher and scientist, is known to have made a wager in which he bet on the existence of God. His rationale was that he would lose nothing if he were wrong, but would gain heaven if he were right. In much the same sense, no one can be certain whether the maltreatment of children can ever be prevented, nor what form preventive action should take. But, like Pascal, the community that wagers in favor of preventive measures has nothing to lose but has very much to gain.

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2. Caffey, "The Parent-Infant Traumatic Stress Syndrome; (Caffey-Kempe Syndrome), (Battered Babe Syndrome)," p. 227.
3. White House Conference on Children, *Report to the President*, pp. 244–245.
4. See, for example, Fanaroff, Kennell, and Klaus, "Follow-Up of Low Birth Weight Infants—The Predictive Value of Maternal Visiting Patterns"; Ambuel and Harris, "Failure to Thrive: A Study of Failure to Grow in Height and Weight"; Shaheen et al., "Failure to Thrive—A Retrospective Profile"; Elmer and Gregg, "Developmental Characteristics of Abused Children"; Weston, "The Pathology of Child Abuse," in *The Battered Child*, ed. Helfer and Kempe, 1974, pp. 61–86; and

Klein and Stern, "Low Birth Weight and the Battered Child Syndrome."

5. Reinhart et al., "Child Abuse: A Handbook," pp. 38–39. For a discussion of the effects of early separation, see Klaus and Kennell, "Mothers Separated from Their Newborn Infants."
6. Bronfenbrenner, "The Origins of Alienation," p. 54.
7. Reinhart et al., "Child Abuse . . . ," p. 100.
8. These data are reported by Bronfenbrenner, "The Origins of Alienation," pp. 53 and 55.
9. Reported by Hyman, "International Sample Survey," pp. 606–607.
10. Reported by Bronfenbrenner, "The Origins of Alienation," p. 54.
11. Bronfenbrenner, "The Origins of Alienation," p. 54.
12. The use of "block parents" was suggested by Dr. Urie Bronfenbrenner in a personal communication and is based on a proposal developed by one of his graduate students.
13. White House Conference on Children, *Report to the President*, p. 245.
14. Bronfenbrenner, "The Origins of Alienation," p. 61.
15. White House Conference on Children, *Report to the President*, p. 248.
16. Ibid, pp. 248 and 254.
17. Ibid, p. 255.
18. For further discussion, see White House Conference on Children, *Report to the President*, p. 249; and Bronfenbrenner, "The Origins of Alienation," pp. 57 and 60.
19. Bronfenbrenner, "The Origins of Alienation," p. 60.
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Appendix
Examples of Community Programs*

Following are four examples of communities that are making a coordinated effort to deal with the maltreatment of children. While various communities in the United States have programs that would serve as excellent examples, the four included here were selected because they illustrate a range of different types of communities; alternative techniques for program development; and various structures, services, and objectives.

- The program in Honolulu is centered on a strong protective service unit that functions as the agency of prime responsibility; a children's hospital; a multidisciplinary consultation team; and strong community support.
- In Greater Lehigh Valley, Pennsylvania, the child abuse program ha. two unique features: it is based on a two-county unit and, unlike many communities, has developed a strong and innovative therapeutic component.
- Montgomery County, Maryland is a suburban county having one of the highest per-capita income levels in the United States. The development of its program was sparked by work of the local 4-C Council and the backing of a strong county executive.
- Uptown Chicago is in some respects the opposite of Montgomery County. Part of an "inner city," it has a relatively large population of day laborers, poor people, and transients. The program here is an example of coordination in a large city.

Each of these communities has found its own way of working toward a community program based on its own needs and resources. No community's program would be ideal for any other. These examples are presented not as prepackaged models that can be installed in any community, but as programs that have been adapted to local needs by concerned people within the community.

*Adapted from material written for the Office of Child Development in 1974 by Deborah Adamowicz, Brandegee Associates, Inc.

Honolulu County, Hawaii[1]

To me, Honolulu has the ultimate in coordination and in what may be called a "team approach" . . . This is a classic example of what ought to be in terms of a sound protective services program.

Vincent De Francis, Director of
the Children's Division, The American
Humane Association

The concepts "protective services" and "team approach" are relatively new, even among professionals. Yet on the island of Oahu, Honolulu County, Hawaii, both have been developing for years.

In 1937, Hawaii established the Department of Public Welfare (DPW)—the predecessor of the present Department of Social Services and Housing (DSSH)—to protect children and prevent family breakdown. In 1956, the DPW, the juvenile court, and the police department jointly developed "Operation Help," an outreach program to initiate social services on a 24-hour basis to families in crisis.

The enactment of a mandatory child abuse reporting law in 1967 was the first of a series of events that culminated, two years later, in the establishment of a multidisciplinary protective service center for the island. With the passage of the reporting law, the DPW lacked sufficient staff to handle the increasing caseloads. The result was predictable: needed services were not being provided. Community accusations that the Department's Oahu branch was not adequately protecting children resulted, in 1969, in special state legislative action providing for additional staff positions, the re-establishment of the protective service unit (created in 1957 but later discontinued), and funds for a collaborative team. Late in 1969, DSSH established the Children's Protective Services Center.

Serving the 640,000 people of Honolulu County, Oahu, the Cer er is housed in a rented building on the grounds of Kauikeolani Children's Hospital (KCH). As Figure 3 shows, the Center comprises three components: the DSSH Oahu Branch Protective Service Unit, Kauikeolani Children's Hospital, and a community

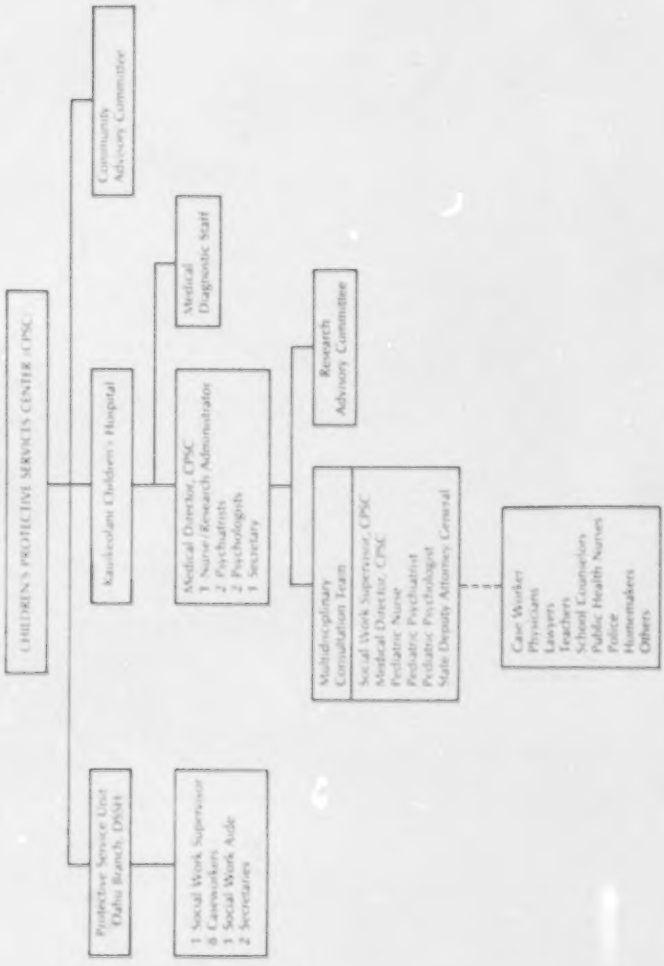

Figure 3. Components of the Children's Protective Services Center.

advisory committee. An annually negotiated contract between DSSH and the hospital clearly delineates responsibilities between the social work and medical components of the Center. Funding presently comes through state and federal monies.

According to Dr. Vincent De Francis: "The beauty of the Honolulu program is that it can be replicated anywhere. It does not require any enormous investment of funds, provided there's an existing protective service operation. All it needs is the designation of the unit and the procuring of consultants." But Dr. George Starbuck, the medical director of the Center, notes that while many hospitals use the collaborative team approach, he is not aware of any community program that replicates the Oahu model in its entirety.

The DSSH Protective Service Unit

Oahu's protective service unit includes eight caseworkers, a supervisor, a social worker aide, and clerical support. Crisis oriented, the unit is responsible for the social work assessment of reported families and for transferring each case, within 90 days, to an appropriate unit for ongoing treatment and follow-up care. The average monthly caseload per social worker is about 20 families; to date, the social work turnover has averaged three positions a year.

The unit receives all reports of suspected abuse and neglect through the hospital's 24-hour switchboard. Table 4 is a summarized list of cases reported from 1967 through 1973 and of the number of confirmed reports each year. (Hawaii's reporting law includes emotional deprivation and sexual abuse as reportable conditions.)

Table 4

Reports of Abuse and Neglect, Oahu

	1967	1968	1969	1970	1971	1972	1973
Received	88	67	375	924	934	1051	962
Confirmed	69	49	204	455	455	480	461

Kauikeolani Children's Hospital

The medical component of the Center includes a full-time salaried medical director, a full-time nurse, two psychiatrists, two psychologists, and a secretary—all paid through annually negotiated DSSH-KCH budget funds. The hospital, through its medical staff, is responsible for conducting the diagnostic study of children and parents and for providing medical treatment and hospitalization when needed. (This is modified if a family prefers to have the medical workup done privately.) In addition, members of the medical staff serve as consultants to protective service workers, both from the Center and from outside units.

The medical director reviews the medical aspects of each case and all diagnostic workups; can obtain medical information for a social worker if necessary; is available to professionals throughout the state for medical advice about cases; discusses medical diagnosis, prognosis, and treatment with reported families; and, if the caseworker desires, can act as a counselor to both parents and children.

Multidisciplinary Collaborative Teams. In addition to these various functions, the medical director has established and maintains two collaborative teams. The original team has been meeting since December 1969 to provide recommendations to caseworkers on one or more generally complex cases a week; the second team was formed in response to the increasing work of the Center.

Team members include the Center's social work supervisor, the medical director, a pediatric nurse, a state deputy attorney general, a pediatric psychiatrist, and a pediatric psychologist. In addition to these fixed members, team case reviews include the social worker in charge of the case and sometimes physicians, lawyers, teachers, school counselors, public health nurses, police, or others whose knowledge of the family may be needed. As part of an outreach effort, the teams periodically meet with social workers from units outside the Center and from private agencies to consult on cases.

The function of the collaborative teams is to recommend the most feasible treatment plan for the family. However, the social

worker presenting the case retains final responsibility for deciding on and implementing the treatment plan, prior to referring the case for ongoing treatment and follow-up.

If a parent or child requires therapy, it is arranged if possible with someone who has not done the diagnostic workup of the family. Protective service workers typically attempt to involve the parents in the problem-solving process. For example, if removal of the child is indicated, most caseworkers will recommend temporary separation to the parents and will suggest possible alternatives such as placement with friends or relatives, in the protective service unit's emergency shelter, or in a foster home.

The Research Advisory Committee. Through the initiative of the medical director, the Center has also established a Research Advisory Committee, consisting of the medical director, a nurse/research coordinator, and professionals in maternal and child health, psychiatry, psychology, and social services. The Committee has reviewed pertinent literature; organized a retrospective study of certain cases; and assisted in developing forms for requesting the services of the collaborative teams and for recording team recommendations, the protective service disposition, and follow-up reports.

The Community Advisory Committee

The third component of the Children's Protective Services Center, the Community Advisory Committee represents a cross-section of the community including various family-serving agencies. The Committee can deal with the community at large in a manner not possible for DSSH. For example, it can seek public funds to support increased community services. The Committee can also review and assess problems in the community and pass its recommendations on to DSSH or the Center; in turn, through the Committee, the Center can seek help from community groups.

As part of the Center's community services, the medical director, social work supervisor, and nurse conduct an extensive education program—for schools, physicians, nurses, social workers, the police, ambulance drivers, and both public and private community organizations.

Future plans for the Center include the possible addition of a therapeutic and follow-up unit, group therapy, and a parent aide program. In addition, there are plans to develop a program geared to the prevention of renewed abuse in reported families and to the study of low-birth-weight infants who are at high risk for abuse and neglect. The latter phase of this program is already underway.

In a paper presented at The American Humane Association's Second National Symposium on Child Abuse, held in October 1972, Rade Awana, social work supervisor of the Children's Protective Services Center, listed the following as results of the program: children and families in crisis are being served quickly and more efficiently; the Center's interdisciplinary approach contributes to "more healthy family functioning"; and each participating profession continues to learn from the others.[2]

Slowly, the Center is moving toward its objective of providing, in Awana's words, "the best protective services to children and their families in Honolulu."[3]

Greater Lehigh Valley, Pennsylvania

Coordination Across County Lines

Lehigh and Northampton Counties are two of the most affluent in Pennsylvania. Together they comprise the Greater Lehigh Valley. The population of approximately 470,000 includes all socioeconomic levels and a variety of ethnic and cultural groups. The urban centers of Bethlehem and Allentown are surrounded by extensive rural areas.

In the late 1960s, Dr. John Wheeler, an Allentown pediatrician, was seeing in his private practice repeated incidents of abuse in middle-class families. Rather than putting the incidents out of his mind, Dr. Wheeler decided to find out what the agencies in his county were doing about the problem. The answer: not only did Lehigh County lack a specific program for abusive families, but the typical community response to the parents was punitive.

Wheeler then contacted a former medical school classmate, Dr. C. Henry Kempe, who is now director of the National Center

for the Prevention and Treatment of Child Abuse and Neglect in Denver. He obtained information on developments in the field of child protection, community-based program models, and therapeutic approaches. His inquiries eventually led to a series of meetings among the directors of the Lehigh and Northampton Counties Children's Bureaus, the director of the Base Service Unit of Lehigh County Mental Health/Mental Retardation (MH/MR), and Dr. Raymond Seckinger, a psychiatrist in private practice. Their purpose in meeting was to consider a specific group therapy program for parents. In late November 1969, the first local therapy group was formed, under the sponsorship of the Lehigh County MH/MR Base Service Unit.

The Child Abuse Group, as the group therapy program is called, and the administrative meetings that led to its establishment, were the beginnings of a coordinate two-county program for the Greater Lehigh Valley. While many of its components have been developing over the past five years, much of the Coordinated Child Abuse Program is still in the formulative stage. The description below includes functioning aspects as well as some new and some proposed additions to the Program. Beginning in October 1974, the expanded Program is being partially funded over the next three years by the Pennsylvania Department of Public Welfare.

The Program provides services only to families who have the problem of child abuse or who refer themselves as potentially abusive. For families in which children are neglected, the Children's Bureau in each county provides protective services; however, services to these families are separate from the Child Abuse Program. The 1974 statistical accounting of child abuse reports is not complete as of this writing, but an informal survey is presented in Table 5 below.

Table 5
Child Abuse Reports, 1974

	Validated	Validated	Indeterminable	Total
Lehigh County	27	4	9	40
Northampton County	13	4	8	25

Objectives

The Coordinated Child Abuse Program has six broad objectives:

- to prevent the abuse of children by effecting psychological changes in parents and responsible adults
- to enhance children's development
- to modify the home environment so as to lessen stresses that may precipitate abuse
- to improve the effectiveness of the Program's training component
- to conduct research that will add to the understanding of both the etiology of abuse and the effectiveness of different treatment modalities
- to further educate the community in order to create a more favorable climate for positive family change.

Coordination and Administration

According to Dixie Bair, supervisor of the child abuse unit of the Lehigh County Children's Bureau, community cooperation and the coordination of services are the "key" to the Child Abuse Program. Coordination functions at several levels, as Figure 4, an organization chart of the proposed Program, shows.

At the administrative level, the Program in each county is under the auspices of the respective county's Children's Bureau, with the Bureau's director or designated assistant responsible for administration. In addition, a program coordinator—responsible for supervising the integration of all components of the county's program—has been added to the staff of each Children's Bureau. Their specific duties include: maintaining communication among the agencies and resources involved and resolving any internal conflicts that may develop within the Program; developing liaison with other local, state, and federal programs; proposing changes in administrative policies and procedures; developing training programs; spearheading community education; arranging consultations and case conferences on specific cases; coordinating the work of all involved agencies once a treatment plan

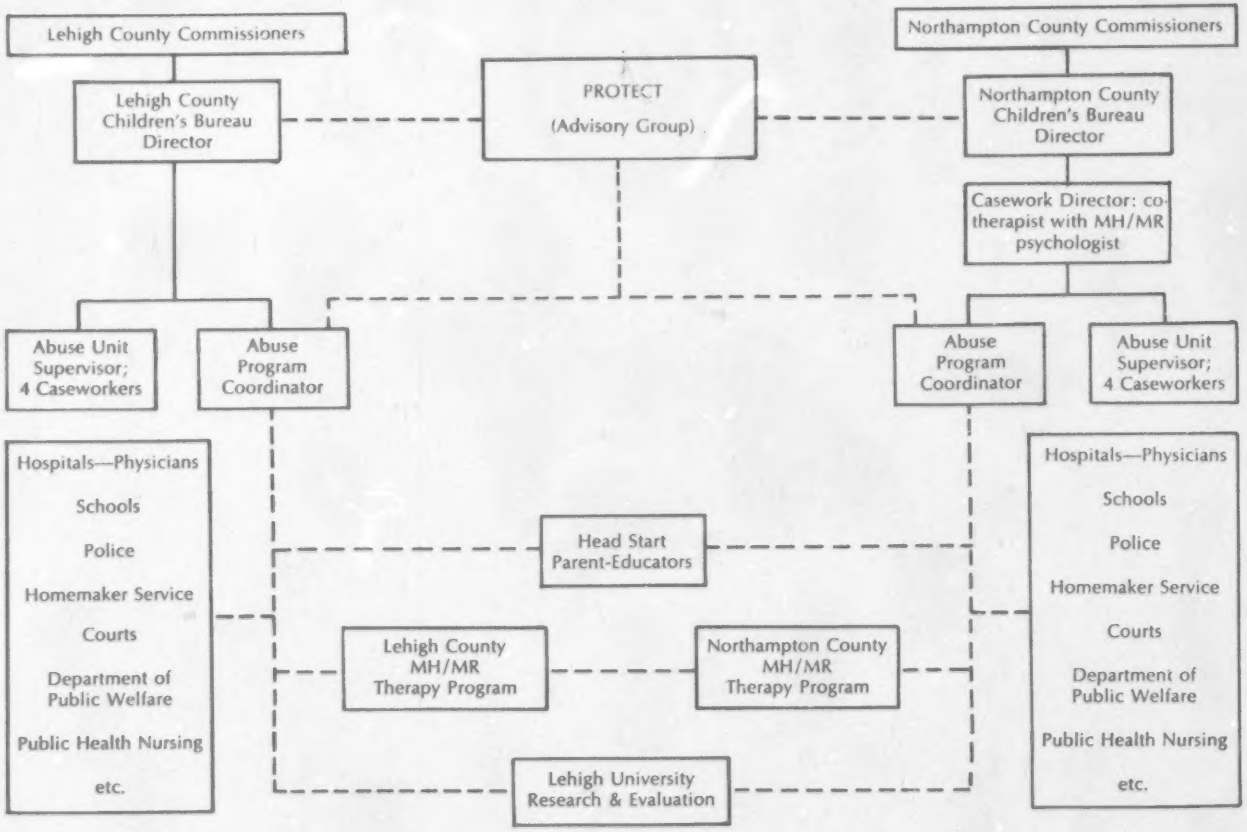

Figure 4. Components of the Coordinated Child Abuse Program in Lehigh and Northampton Counties.

has been developed for a family; providing ongoing follow-up on all cases; overseeing the collection of statistics on abuse cases; and handling information requests concerning abuse and the Child Abuse Program.

The coordinating mechanism between the two counties is PROTECT—an unincorporated, nonprofit association of professionals and interested individuals from the community. Begun in 1973, PROTECT functions as an advisory group to the agencies and professionals in the Program. There are currently 32 members representing various disciplines and every agency involved in the Program.

Reporting and Diagnosis

In Northampton County, all reports of suspected child abuse are handled initially by intake workers at the county's Children's Bureau. In Lehigh County, initial handling is shared by Children's Bureau intake workers and caseworkers from the child abuse unit. All reports are received by the intake department; but approximately 50 percent, particularly those resembling "classic" child abuse cases, are forwarded to the abuse unit supervisor, who assigns cases for immediate investigation to the unit's caseworkers. In the future, the child abuse unit may possibly receive and investigate all child abuse referrals in addition to providing ongoing services for accepted cases.

If a report is made by a neighbor, relative, or other nonmedical source, the intake worker will visit the reported family within 24 hours and, if necessary, take the child for medical evaluation. If an apparently abused child is seen first at a hospital dispensary, the attending physician will admit the child, begin a thorough medical work-up, and make an immediate oral report to the Children's Bureau. The hospital's social service department will later contact the Bureau and, if indicated, will file a written report. Within 24 hours of receiving the written report, the Children's Bureau intake worker will visit the child in the ward, speak with the attending physician, and then meet with the parents.

Upon receipt of a written report from any source, intake workers make an immediate oral report to the local police, who

file the reported information. In Lehigh County, the police take no further action unless requested; in Northampton County, the local police department and the Children's Bureau mutually decide if and how the police should be involved in the case.

Within 24 hours after receiving a written report, the intake worker begins a comprehensive psychosocial evaluation of the family. Based in part on this evaluation, the Bureau must determine whether placement of the child—either voluntary or court ordered—is necessary. The next decision is whether or not the parents are "group material"—can they function in and benefit from the group therapy program? A "custom-fitted" treatment plan is developed for every family.

The intake process ends once the parents are referred for treatment and planning for the child is completed. A child abuse unit caseworker is then assigned the case, if it has not already been assigned to the unit during the intake process. Currently, the average caseload per abuse unit caseworker in Lehigh County is 20 families; in Northampton County, 15.

The Greater Lehigh Valley Program also includes a child abuse consultation service, available to any physician at no charge to the patient. Headed by Dr. Wheeler, the service will assist attending physicians in the evaluation of children and the course of action to be taken.

Treatment

Since the initiation of the Child Abuse Group, an increasing array of family-oriented treatment services has been developed in the Greater Lehigh Valley.

Parent Groups. The original parent therapy group, led by psychiatrist Raymond Seckinger, was open to parents from both counties, with caseworkers involved with the families participating in the group. A year later, the clinic director of the MH/MR Base Service Unit, Helen Ruch, a psychiatric social worker, joined the group as co-leader to provide individual counseling to group members. Approximately 18 months after the initiation of the group, one protective caseworker from each county was assigned

to handle all abuse cases, and each became a permanent member of the group. Abuse unit caseworkers are now assigned to the groups.

Child abuse reports in the Greater Lehigh Valley increased about 900 percent between 1969 and 1974, and two additional therapy groups have been formed. Northampton County now has its own group, and Lehigh County has two. Group, individual, and family therapy, as well as marital counseling, are available to parents in both counties. A future goal is to have bilingual staff provide casework service for Spanish-speaking families.

The broad goals of the therapy groups are to "refine" and "remodel" aggression; to increase self-identity; to guide in family planning; to define and refine interaction between nuclear- and extended-family members; and to improve marital and parent-grandparent relationships, parenting capabilities, child-rearing practices, and impulse control. The groups are also concerned with prevention—aiming to prevent further abuse in member families that have previously been reported and to prevent the first incident in self-referred families that have identified themselves as potentially abusive.

The success of the groups is illustrated by the recidivism rate: previously over 50 percent, it has dropped to zero for parents who have completed the entire therapy program. However, there have been four or five instances of repeated abuse—in the form of physical injury, development of a "failure to thrive" condition, or emotional disturbance affecting the child—in families who withdrew prematurely from the treatment program against professional advice.

The Children's Bureau caseworkers assigned to families in the therapy program provide various services. They initially prepare the parents for the program; transport them and their children to and from the weekly group sessions; and, when appropriate, provide individual therapy, marital counseling, and family therapy. Caseworkers also utilize any available community resource to help the family. If necessary, caseworkers help the parents manage a budget or secure better housing, transport them for medical attention, and provide them with child devel-

opment information. Once the parents have successfully completed the therapy program, the caseworker maintains service contact for approximately six months.

Parent Education. Among the recent additions to the Child Abuse Program is a pilot program in which parent-educators, employed and trained by the local Head Start program, provide supportive and preventive services to parents. The goals of the program are two: to increase the parents' self-confidence and self-esteem by increasing their teaching skills and enhancing the learning environment of the home; and to increase the learning capacity, self-esteem, and emotional well-being of the children. There are plans to expand the program in its second year to include education of foster parents who are caring for children previously abused by their natural parents.

For approximately one and a half hours every other week, parent-educators "focus" on a specific preschool child of the family (although other children from the family and the neighborhood are included in activities) and the parents in their home. The parents are taught skills to facilitate their children's development, behavioral expectations appropriate to the children's developmental level, and constructive methods of rewarding and disciplining children. The program will also include group meetings for mothers, with lectures and discussions on such topics as nutrition, health, and psychological problems.

Treatment for Children. When one of the parent therapy groups meets, the preschool children from each family are brought to a "play" group for group activities, social stimulation, and observation by volunteers. These groups are sometimes videotaped for diagnosis by the child-psychiatrist consultant, for playback to the parent group, or for training purposes.

There are also plans to expand the availability of therapeutic day care for abused children and their siblings; to develop a 24-hour crisis nursery that would include temporary "rooming-in" facilities for mothers and children; and to develop in each county a day care facility in the Base Service Unit (or wherever the parent groups meet).

Education and Training

The education component of the Coordinated Child Abuse Program includes both public education and the training of professionals.

As David Lehr, program coordinator for Lehigh County, explains, child abuse is not the problem of welfare agencies alone: "What we hope to do is to educate the community to the fact that this is a community problem—that everybody has to pitch in. A particular point emphasized to the community is that child abuse can happen in anybody's family and that all parents are vulnerable." Though newspaper articles and a brochure describing the program are used, speakers are the main source of public education. The program coordinators and professionals from PROTECT regularly speak to church and PTA groups, junior and senior high school classes, college students, hospitals, medical societies, and other community groups.

Training for professionals had been conducted on a somewhat "hit-or-miss" basis in the past, but has become increasingly more formal. Currently, there are plans to develop a comprehensive training program over a three-year period. In 1975, the first year, all professionals, including medical and school personnel, and paraprofessionals involved in case management are receiving in-service training—including workshops, observation of other programs, consultation with professionals outside the Lehigh Valley, and ongoing training conducted by local professionals. In the second year, training will be provided for a limited number of professionals throughout the state. In the third year, the Program intends to make available a comprehensive "training package" that can be adapted to the needs of any community.

Research and Evaluation

Also projected for development over a three-year period is the research and evaluation segment of the Program. This segment, which is being conducted in cooperation with Lehigh University, has several general aims: to develop qualitative measures of criteria relevant to the objectives of the Program; to assess the degree to which these objectives are achieved; to develop controlled research on the etiology of child abuse and

the prediction of high-risk families; to assess the extent of child maltreatment locally; and to evaluate the effectiveness of training.

Five specific outcomes are anticipated from the first year's research activity:

- an annotated bibliography on child abuse
- an analysis of evaluation methods for assessing the backgrounds and personality dynamics of abusive parents, the developmental levels of abused children, the parent-child interaction, and the home environment
- a comprehensive record-keeping system for involved agencies, with a manual explaining its use
- a set of research-design models for use in testing hypotheses about the causes and dynamics of child abuse
- a design and a set of procedures for conducting a Lehigh Valley census of child abuse.

These initial research products will be the bases of the research and evaluation conducted in the second and third years. They will be available for use in other programs.

Montgomery County, Maryland

It Takes a Tragedy

In May 1972, a child in Montgomery County, Maryland was tortured to death by her parents. The incident was followed by sensational press coverage and drew the attention of local citizens and government to the problem of child abuse and neglect. The essential question they raised: How could such a thing happen in one of the most affluent counties in the United States—a county with one of the highest levels of public education and with a range of social services beyond the reach of most communities? There was a sense of searching for a scapegoat.

A suburb of Washington, D.C., Montgomery County has a population of approximately 500,000. The agency mandated by law to protect children is the protective service unit of the

county's department of social services. In the county, there are various other public agencies involved in the welfare of children, as well as a 4-C (Community Coordinated Child Care) Council—a private organization dedicated to mobilizing and coordinating community opinion and action toward better child care.

By mid-summer, the 4-C Council had set up a Child Abuse Committee, with both lay and professional members, to study the county's protective service system, identify local needs, and suggest possible solutions. The Committee's role was that of a catalyst. Its members investigated how other communities respond to the problem of maltreatment, recommended the creation of a coordinating task force, pressed for improved legislation, educated the public about the problem of abuse and neglect, and sought public support for positive action.

In November 1972, Montgomery County Executive James B. Gleason established the task force recommended by the Committee—the Executive's Task Force on Child Abuse. His reasons for creating the Task Force were basically three: he recognized the government's responsibility for protecting children, the need to improve and develop protective and rehabilitative services locally, and the likelihood that improved services would require county funds. More than a general study group, the Task Force was charged with developing specific programs and recommendations, determining their costs, and planning their implementation.

The Task Force is co-chaired by the director of the county's office of human resources and a representative of the 4-C Council. Other Task Force members include top county administrators from the public school system's pupil personnel section, the health department, the department of social services, the department of juvenile services, the juvenile section of the police department, and the state's attorney's office, as well as a juvenile court judge and a representative of the six area hospitals. The Task Force held weekly meetings from January to May 1973, and has met biweekly since. Approximately every fourth meeting is open to the public.

Early meetings were devoted to establishing a viable working

group. Diane Broadhurst, the original co-chairwoman representing 4-C, describes the atmosphere of the initial meetings as one of apprehension: "Everyone was looking for someone to blame for the child's death. In my experience, the same psychodynamics tend to occur over and over. It seems to take something dramatic—a tragedy—to galvanize a community into action; then people begin to look for somebody to blame. But the simple mechanics of getting together once a week and talking began to produce a positive change."

The Task Force initially addressed itself to problems of interagency cooperation and coordination. Its members jointly studied procedures within and among agencies, they exchanged information, and they learned from one another. As communication among the members improved, coordination among the agencies they represented gradually began to develop.

Broadhurst feels that the improved coordination of services in the county owes as much to the county executive's backing of the group as it does to the work of the Task Force itself: "In getting organized, it helps tremendously to have the backing of the community's top political executive. Lacking that, there's too much time, and money, and effort required to get what you need."

The Task Force has impacted the way Montgomery County—and, to some extent, the entire state—deals with child abuse and neglect. Its impact has occurred in five basic areas: legislative change, case management, education and training, long-term treatment, and coordination.

Legislative Change

Soon after its inception, the Task Force joined the 4-C Council in working to revise Maryland's child abuse law. They analyzed and suggested changes to proposed legislation, educated the public to the need for legislative revision, testified before the House Committee on the Judiciary, and submitted written testimony to the state senate in support of one of the proposed bills. Partly due to their efforts, the state adopted new legislation in May 1973. The revised law now designates the local department of social services and the local law enforcement agency

to receive and jointly investigate all reports—a practice that was policy in Montgomery County fully a year before state law required it.

Despite the legislative revisions, the Task Force felt that the Maryland statute needed to be further improved. In mid-1973, its subcommittee on legislation drafted an amendment that proposed eliminating the requirement for parental consent for the medical examination and treatment of a child if abuse is suspected, mandating all Maryland physicians to examine such children, and granting immunity to any individual or institution involved in the examination or treatment. This amendment, introduced into the legislature by County Executive Gleason, was subsequently incorporated into a bill that included a proposal to expand the legal definition of abuse to include sexual molestation and exploitation of minors. The bill was passed by the legislature and signed by the governor, effective July 1974.

Case Management

Probably the greatest change in Montgomery County's approach to abuse and neglect has been in the way cases are identified, investigated, and managed. Among its first accomplishments, the Task Force replaced the state's long and complicated form for written reports with a single, clearer form to be used by all county agencies and professionals involved in child care. In response to another Task Force recommendation, a single telephone number now serves as a 24-hour hotline for reports from anywhere in the county.

Within one hour of any report of suspected abuse or gross neglect, a juvenile section police officer and a protective service caseworker jointly investigate. In most cases, the child is immediately taken for medical examination. The social worker, accompanied by the police officer, is authorized to take a child into temporary protective custody if needed. Removal must be justified the following court day in juvenile court, and the court determines the immediate disposition of the case. If the child is temporarily removed from the home, a later hearing is held for a more permanent disposition.

A protective service caseworker needing consultation on the

management of a particular case can bring the case before the county's Child Protection Team. Established upon the recommendation of the Task Force, the Team has been meeting weekly since February 1974. Its function is to provide multidisciplinary consultation and to review cases periodically. Permanent members include a pediatrician, a psychiatrist, a public health nurse, an attorney, a pupil-personnel supervisor from the public schools, a protective service supervisor, and a police juvenile officer. In addition, other professionals involved in a specific case are invited to become *ad hoc* team members.

Protective service workers can also obtain consultation on specific cases from the health department Evaluation Team, located at the district court since February 1973. The prime function of the Evaluation Team—which comprises a pediatrician, a psychologist, a psychiatrist, a social worker, an education diagnostician, and a pupil-personnel worker—is to assist the court in case evaluation.

Another recommendation of the Task Force that has served to improve case management was a budget increase of almost $47,000 in county funds to provide for more protective service caseworkers. Early in 1972, the local protective service unit had three caseworkers and one supervisor; caseloads averaged 35 to 40 cases per worker. Today, the complement is 15 caseworkers, three supervisors, and a clerk-typist. Caseloads average about 25 per worker.

The health department, the juvenile section of the police department, the department of juvenile services, and the office of human resources have also increased their staffs. A new district court judge has been appointed who will devote 60 percent of his time to juvenile court; and a new position for assistant state's attorney has been assigned to the juvenile court.

Education and Training

Among its initial charges, the Task Force was to plan broad public education and professional training programs. Since the local 4-C Council had already launched educational programs—including a child abuse conference for professionals in 1972—the Task Force agreed that 4-C should handle the major educa-

tional effort. The 4-C Child Abuse Committee has compiled a significant reference collection on abuse and neglect, housed in the public library system; established a speakers bureau; and provided videotapes for community information and the training of speakers.

Most of the agencies represented on the Task Force have conducted periodic or ongoing training programs for their staffs. Task Force members routinely plan and frequently participate in these programs. Relevant training has been provided to the protective service staff; all administrators, supervisors, and pupil-personnel staff of the public school system; the entire health department; police officers; day care employees; and the staffs of at least two local hospitals.

In addition, the county's public school system has undertaken a major training program—Project PROTECTION.* Funded by an $80,000 federal grant, the program includes training for the county's 8,000 public school teachers on how to identify, report, and work with abused and neglected children; training for non-public school teachers; and curriculum study and policy revision.

Treatment

Child abuse is a felony in Maryland. Montgomery County has adopted a policy of avoiding criminal prosecution whenever possible in favor of treatment and rehabilitation, although many of the treatment modalities needed are presently lacking. In addition to providing a typical range of placement and counseling services, the protective service unit is sponsoring a group therapy program for abused adolescent girls, and is working with the public school system's adult education program to develop an effective group program for parents. The health department provides various therapeutic services, and area health centers offer individual counseling or psychotherapy, health education, and help in parenting.

Extending the range of treatment is one of the Task Force's immediate concerns. There are plans to develop therapeutic

*For further information, contact Diane D. Broadhurst, Coordinator, Project PROTECTION, Montgomery County Public Schools, 850 North Washington Street, Rockville, Maryland 20850; (301) 949-7888.

modes and services now unavailable in the county: lay therapists, Parents Anonymous, crisis nurseries, and family crisis-care homes. Improvements in basic mental health services and in basic maternal and child health services are also planned.

Coordination

At the case level, coordination is handled by protective service workers, who are mandated to follow each case. The Child Protection Team serves as an additional case-coordination mechanism.

At the countywide program level, coordination is shared by the Executive's Task Force and the county's child protection coordinator, a full-time administrator of the Child Protection Team. The coordinator, with an administrative assistant and an administrative aide, assists the Team in developing procedures, scheduling and giving notice of meetings, and preparing materials. In addition, the three maintain liaison with government departments represented on the Team and with other public and private agencies; collect and analyze data related to child maltreatment; oversee the development of treatment resources in the community; design and evaluate treatment and service programs; plan and implement education for professionals and for the community; and periodically report on community resources, gaps in available services, and recommended changes in policies, procedures, or programs.

Montgomery County is in many ways unique. It is an affluent county, with a local government committed to and capable of effecting needed change. But its efforts to develop an effective community program typify a number of the problems and issues that any community might face. And its reported incidence of abuse and neglect—302 referrals between January 1 and June 1, 1974—is evidence that child maltreatment is as common to the suburbs as it is to any community.

Uptown Chicago

A Thorough Planning Job

Uptown Chicago, a community of about 140,000 people, has a wide array of health and social service agencies to serve its extremely diverse population. A broad range in housing prices reflects the local mix of socioeconomic groups: from stable and affluent families to large numbers of migrants, transients, and day laborers. Uptown residents include people from Appalachia and the South, the Middle East, Asia, significant Latin American and American Indian populations, and a sizeable number of former mental patients.

Among the many service agencies in Uptown Chicago, some serve the community, some the city, and others the county or state. Some are privately funded; others receive funds from the city, the state, or the federal government. Until recently, consistent coordination and communication among Uptown agencies was lacking. There were gaps and overlaps in services, and occasional interagency rivalries. Many of the agencies were handling cases of child abuse and neglect with little knowledge of the services other agencies offered and with little or no success in coordinating the child protective services available.

A major step toward coordination was taken in 1973. A group of service providers, concerned about the fragmentation of services, settled on child abuse as an issue on which they could begin to work together. The group called itself the Uptown Task Force on Child Abuse, and a number of committees were formed to address specific tasks. As it continued to meet, the Task Force attracted service providers from an increasing range of agencies, as well as some community representatives. Today the Task Force represents about 30 Uptown agencies, both public and private.

Two people responsible for the Task Force—Dr. Nahman Greenberg, a psychiatrist at the University of Illinois Medical School, and Paulette Williams, a social worker and planning associate at the Edgewater-Uptown Community Mental Health

Center—were selected, respectively, as the chairman and the executive secretary of the Task Force. The Illinois Department of Children and Family Services (DCFS), the state agency mandated to protect children, assigned a full-time staff person to the Task Force to serve as the internal coordinator.

For the present, the Task Force considers itself a planning group rather than a direct service provider. Members feel that, in the past, programs have been adopted before being thoroughly planned, and without the full participation or consent of those expected to act on them. The Task Force initially decided to step back and do a thorough planning job—spending the necessary time to educate themselves and to resolve interagency conflicts and misinterpretations of roles.

Their objective, according to Dr. Greenberg, has been "to explore the local need for services in the area of child abuse and neglect, to determine where the gaps in services are and what can be done to develop a model program." Improved coordination has been "just a spin-off" of their work, although it is the long-range goal.

Education

Education has been a primary focus in two senses: Task Force members have been educating themselves and evaluating the need for education among other professionals and in the community as a whole.

Self-education comes through discussion of mutual problems and through the work of several Task Force committees. The Background Information Committee collects data on child abuse and neglect, research data, and information on new proposals and programs, both local and national. To help the Task Force better define the community's service needs, a Case Documentation Committee is attempting to identify a cross-section of cases to determine the present situation of previously treated families and the gaps in the services they received.

As another means to determine needs, the Resources Committee sent a questionnaire to 190 Uptown Chicago agencies and institutions, asking what services each could make available and

what each saw as the most serious gaps in existing services. The questionnaries drew an immediate response from 70 agencies. Responses indicated, among other things, the lack of coordination was felt to be a serious drawback. Some respondents urged the Task Force to take on the task of coordination immediately, but the members have so far preferred to remain with their original planning intent—to complete a thorough assessment and to arrive at a comprehensive plan.

The Education Committee was formed partly in response to the need of the DCFS to educate those service providers who are required by law to report. The committee is responsible for exploring the community's educational needs and for developing programs on such subjects as general information about abuse and neglect, legal considerations, community resources, child development, and effective parenting.

The Orientation/Membership Committee serves as the Task Force's public relations body. It is responsible for disseminating information about the Task Force and for recruiting other agencies, groups, and individuals as members.

The Task Force has not yet made a direct attempt to involve community people, except for an "open house" sponsored by the Steering Committee to inform the public about the program. The Task Force members recognize the need for further community involvement, but feel they need something more definite than they have yet produced in order to get people to respond. But, as Paulette Williams notes, the work of the Task Force is approaching the point of needing some "reality testing" in the community to see how closely the group's plans match actual needs.

Identification

Most of the agencies which responded to the Resource Committee's questionnaire stated their need for more training in the identification of abused and neglected children and of family situations where it might occur. Dr. Greenberg, in his own estimate of needed services, included "much better identification procedures" as well as "developing the capacity of the community itself to reveal where the problems are."

As a result of the Education Committee's work, a task force on child abuse has been formed at one Uptown school. Its purpose is to identify suspected cases of maltreatment and to direct families to appropriate community services.

At present, reports of suspected abuse typically go to the police, and cases are usually taken to court—a procedure said to contribute to the reluctance of doctors and others to report. The Task Force's Court and Legal Services Committee has been examining the policies and practices of the juvenile court, and will make recommendations for changes and possible realignment of roles. Committee members have established good working relationships with several of the Cook County juvenile court personnel including some judges. The committee is also looking into the legal and political feasibility of greater community control over abuse and neglect cases.

Treatment

Despite the abundance of agencies in Uptown Chicago, there is a critical shortage of stress-relief, crisis-oriented, and treatment services. According to Paulette Williams, among those lacking are 24-hour crisis nurseries, provisions for immediate financial assistance and housing, parents' groups, homemaker services, short-term crisis centers to serve entire families, and resources for the care of abandoned children. In addition to noting these specific gaps, she describes present treatment plans as usually geared only to the protection of the child, rather than being coordinated plans for the treatment of each family as a whole.

In response to these and other problems, the Program-Writing Committee is charged with studying various models of service, examining community needs (through the input of other committees), developing a philosophy of service related to the local situation, and writing a program for a comprehensive, coordinated network of services. Its goal is to devise a coordinated system that not only is geared to the particular problems and needs of the Uptown community but can be useful as a model anywhere.

Coordination

As yet, there is no formal structure in Uptown Chicago for

the coordination of services at either the administrative or the case level.

At the case level, lack of coordination is recognized as a serious gap. Task Force members agree on the need to coordinate the separate services that an individual family may require from various agencies, but have not as yet agreed on the person or agency most appropriate for the task. One suggestion that the Task Force is debating is the development of one centralized service to handle intake, ensure careful diagnostic evaluation, and coordinate individualized treatment. An advantage of such a separate unit would be its neutrality. But there would be disadvantages: existing agencies would have to relinquish some case control, and funding would be required.

In November 1974, the Task Force submitted a proposal for federal funding of a coordinated community service project. When its proposal was rejected, the group began to re-examine its focus and goals. The Task Force has since incorporated, elected a board of directors, and selected new officers. In addition, the Task Force plans to request representation on the board of the newly funded Metropolitan Area Protective Services Project—a group comprising DCFS and 17 private service organizations attempting to coordinate service delivery for Chicago's entire North Side. (The proposed service area includes Uptown, but the project does not formally involve the Task Force at present.)

As part of its current refocusing efforts, the Task Force plans to gear itself more toward actual service coordination, now that its "ideal model" has been relatively well developed through planning. As Williams notes: "Coordination and development of services could have been attempted more quickly, but it would have been mechanical. We wouldn't have had a common understanding of the function of each agency or even a common concept of child abuse. We've gone out of our way trying to get the agencies committed to a common purpose. We very much believe that a planning phase—during which a true communication of needs, definitions, resources, and so on occurs—is essential for commitment and cooperation in service delivery and coordination in any community."

Although the Task Force has preferred to think through questions rather than to make premature proposals or attempts at formal coordination, some practical benefits of the Task Force are already evident throughout the Uptown community. Representatives of approximately 30 local agencies have improved their mutual understanding and their working relationships, and the agencies themselves have begun to work together more smoothly in serving families.

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For more information about child abuse and neglect, contact:

- The American Humane Association, Children's Division,

P.O. Box 1266, Denver, Colorado 80201. Ask for the association's *Publications on Child Protection* (request price list).

- The National Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado Medical Center, 1001 Jasmine, Denver, Colorado 80220.
- NIMH Communications Center, Rockville, Maryland 20852. Ask for *Selected References on Child Abuse and Neglect.*

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